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ABSTRACT

The case studies in this report describe the Advocacy Components (AC) of seven Parent-Child Centers, giving comprehensive details based on six months of operation. Each site description includes information related to: the community, needs assessment, the relationships with families, family group participation, community resources, project objectives, the relationship of each AC with its Parent-Child Center, and staff organization, background, training, and turnover. Family contact summaries and referral reports are also included. Data tables summarize referrals for all seven AC for the period May-September 1972, and a sample advocacy questionnaire is appended. (SET)

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CASE STUDIES ON THE ADVOCACY COMPONENTS OF SEVEN PARENT-CHILD CENTERS: HOW THE NATIONAL PROGRAM LOOKS SIX MONTHS AFTER START-UP

Prepared for:
Office of Child Development
Department of Health, Education, and Welfare

October, 1972

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Member Agency of the Associated YM-YWHAs of Greater New York

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INTRODUCTION

The background for the creation of the Advocacy Component (AC) of the Parent-Child Centers (PCC), the objectives for the national program, and the method of procedure for the present study of the AC's were all described in detail in a report submitted in June, 1972, to the Office of Child Development (OCD).[1] These topics will not be covered again in the present report which is meant to serve as an interim report.

The purpose of the present report is to provide OCD and the local projects with a detailed picture of where the programs are after six months of operation. The case studies are designed to provide a comprehensive picture of each AC and where it stands in relation to national goals and local project objectives.

The data for the case studies were obtained through on-site visits to each of the projects by Center for Community Research (CCR) staff. Extensive interviews with the Advocacy Coordinators were conducted according to the interview guide presented in the appendix. Informal discussions were held with PCC Directors and with PAC Chairmen. Additional information was obtained from the AC funding proposals and from the previous round of CCR site visits.

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[1] "A descriptive report on the Advocacy Components of seven Parent-Child Centers: How the national program looks at inception." Prepared for Office of Child Development, Dept. HEW, by the Center for Community Research, June, 1972.

The case studies are intended to be descriptive, rather than evaluative. Essentially each case study represents a statement about what the Component is doing, as reported by the Advocacy Coordinator to CCR staff. As can be expected from a case study format the impressions of the interviewers are also included in order to provide a more vivid and personalized picture of the individual programs.

All Coordinators were asked the same questions in order to make comparisons between programs possible. Thus, in certain sections it is reported that a particular Component is not performing a particular set of activities. It should be clear from the outset that a report of no activity within a particular area is in no way intended as a pejorative judgment on the part of CCR as to what a Component should be doing. A careful reading of all seven case studies shows that virtually no Component is doing work in every sphere of activity. Each has its own objectives and particular set of community circumstances. In relation to these, each Component stresses some activities and not others.

Prior to each narrative case study, data are presented on a number of actual contacts and referrals reported to date for AC families. These data are obtained monthly by CCR from the local projects. The data presented here represent summary figures for each project for the period May-September.

The following represents an overview of information obtained from the case studies which are presented in this report.

Needs assessment:

At each AC the needs assessment served at least one of the following functions:

- Provided new information
- Demonstrated purpose and capability to other agencies
- A clinical tool for gathering in-depth ongoing information
- Afforded entré to homes.

Relationship with individual Advocacy families:

The following alternatives are represented by the AC's:

- Regular and periodic home visits to all families (range once a week to once a month)
- Initial visit by AC, followed by no return visits unless the family calls
- Contacts around specific actions only, e.g., referrals

Group participation:

- Mass meetings around major issues have not been attempted in most places.

- Committee formation has proved more difficult than anticipated. In two AC's, Housing Committees are just now getting underway.
- Groups have been formed in several AC's around pre-natal care and teen concerns.

Relationships with agencies:

- Most relationships are centered around facilitating referrals.
- The AC's have, for the most part, developed a thorough knowledge of the facilities and agencies in their communities.
- Changes in service delivery are not readily effected. Agencies lack money and staff; public agencies lack power to change at the local level. At four programs, agencies have made shifts in the hours available to clients or in style of service delivery.
- Inter-agency meetings and cooperation are common to all AC's. At three AC's inter-agency councils have been established. These councils have not yet taken any major policy stands on issues, but the meetings could be a first step in this direction.

Relationships with PCC:

- At five PCC/AC's the relationships are close and cordial. Joint staff meetings, reciprocal referrals, and joint training are standard policy.

- At two PCC/AC's there has been considerable friction and the feeling remains that the two should be separate. Their joining and interdependence is experienced as detrimental to either one or both PCC and AC.

Staff

- Community residents, serving as Advocacy aides have been able to gain entré into the homes and develop rapport with families. The tasks they are expected to perform in terms of data collection, information dissemination, and referral are in many instances very complex. Intensive staff training is a major part of every Component. Such staff training has proved time consuming and some problems have been identified.

Advocacy patterns

While it is really too early to speak of models in a program which has been underway for only six months, certain patterns do seem to be emerging:

- Case advocacy:
  Attempts are made to meet all of a family's needs, in all feasible areas of service. This promotes multiple referrals and multiple home visits. It is essentially a casework approach, in which emphasis is on the ongoing relationship with the Advocate.

- Referral activity:

  Getting the families to the services is the major part of the effort. A major thrust involves educating the families to understand the importance of the service and encouraging their use. AC's are active in making appointments, taking families to agencies, and in follow-through. Works tends to be on a one-to-one basis not only with the families, but also with agencies.

- Class advocacy:

  Attempts are made to meet those needs which are identified as priority needs for the catchment area. The emphasis is on groups of families rather than on individual families, on effecting coordination among agencies, and in some instances on seeking legislative change.

CASE STUDY SEPTEMBER, 1972

ADVOCACY COMPONENT
OF THE
BALTIMORE PARENT-CHILD CENTER

Principal Author: Dorie Greenspan

BALTIMORE, MARYLAND

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BALTIMORE

FAMILY CONTACT SUMMARY [1]

Number of different families telephoned for reason other than to schedule a home visit	61 [2]
Total telephone calls to families, May through September	99
Number of different families visited in the home	110 [2]
Total home visits to families, May through September	400
Number of needs assessments completed prior to May	144
Number of needs assessments completed since May	44
Total number of families dropping from "participation"	6

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[1] For period of May through September, 1972, inclusive.

[2] Total of monthly figures of different families contacted.

BALTIMORE

REPORT OF REFERRALS[1]

MEDICAL REFERRALS	Numbers
ALL MEDICAL (sub total)	196
PERCENT OF TOTAL REFERRALS	(50)
Prenatal care	10
Neonatal care	
Nutrition	36
Immunization	
Check-up	22
Medical coverage enrollment	110[2]
Hospitalization	2
Surgery	1
First Aid	1
Medical appliance	
Family planning	
Eye examination	
Hearing problem	1
Speech problem	
Dental examination	
Dental problem	
Medical miscellaneous	13

PSYCHOLOGICAL REFERRALS	
ALL PSYCHOLOGICAL (sub total)	1
PERCENT OF TOTAL REFERRALS	(*)
Psychological testing	
Retardation	
Psychiatric care	1
Developmental/behavioral problem	
Psychological miscellaneous	

EDUCATIONAL REFERRALS	
ALL EDUCATIONAL (sub total)	1
PERCENT OF TOTAL REFERRALS	(*)
Adult basic education	
Private/special school enrollment	
Facilitating transportation	
College or equivalent enrollment	
Head Start enrollment	
Educational miscellaneous	1

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[1] Totals reported for May through September, inclusive.

[2] Immunizations were given as part of enrollment in some cases.

* Less than 0.5 percent.

BALTIMORE

EMPLOYMENT-RELATED REFERRALS

	Numbers
ALL EMPLOYMENT (sub total)	1
PERCENT OF TOTAL REFERRALS	(*)
Job rehabilitation	
Job training	
Job placement	1
Employment miscellaneous	

HOUSING REFERRALS

ALL HOUSING (sub total)	122
PERCENT OF TOTAL REFERRALS	(31)
Home repair/improvements	3
Furniture/appliances	8
Relocation (ruined quarters)	38
Relocation (more space)	45
Rent payment	5
Eviction	4
Housing loan	
Pest control	16
Housing miscellaneous	3

WELFARE REFERRALS

ALL WELFARE (sub total)	21
PERCENT OF TOTAL REFERRALS	(5)
Food stamps	8
Special welfare services	6
Increased welfare payment	3
Welfare enrollment	
Veterans Admin./Social Security	
Welfare miscellaneous	4

MISCELLANEOUS REFERRALS

ALL MISCELLANEOUS (sub total)	56
PERCENT OF TOTAL REFERRALS	(14)
Help obtain clothing	
PCC referral for enrollment	5
Legal problem	4
General transportation	
Day care	18
Baby sitting	
Help obtain emergency food	2
General information/miscellaneous	27
TOTAL NUMBER OF RESOURCE CONTACTS	398 (100)

THE COMMUNITY

The catchment area

The Baltimore Advocacy Component (AC) uses office space in the rear of the Comprehensive Dental Clinic. The Advocacy Coordinator has a small office at one end of a very long room. He is separated from his staff by approximately fifteen desks that are used by social workers and other assorted Clinic personnel. The walls of the Coordinator's office adjoin those of dental examining rooms and so the wails of children having their teeth fixed are a common interruption.

The five Advocacy staff members have partitioned off a small square of space at the far end of the room. A large, free-standing bulletin board serves to separate them from the clinic staff and announce to visitors the presence of the Advocacy Component. The location in the midst of a shopping center is convenient to residents of the catchment area. Within the shopping center are also the East Baltimore Medical Plan, the Legal Aid Society and, of course, the Comprehensive Child Care Clinic. Johns Hopkins Hospital, Head Start, and the Parent Child Center are all within easy walking distance.

Behind the shopping center is the Lafayette-Douglass Housing Project. It is a large project, housing approximately 8,000 persons, and is a mixture of garden-type and high-rise apartments. The average Advocacy family pays between $26.00 and $35.00 per month for an apartment in Lafayette-Douglass. Rent is on a sliding scale so that some families pay over $70.00 per month while others pay below $25.00.

From the outside Lafayette-Douglass looks like so many other urban housing projects, brick and concrete and an occasional spot of green. Inside, the apartments are reported to be in poor condition. Rats and roaches are severe problems as are uncovered radiator pipes which are hazardous to children. The floors are concrete and the concrete dust is a problem to persons with respiratory ailments, to say nothing of the housekeeping problems it presents.

The target population

Over 90% of the families served by the Advocacy Component are female-headed. Of 56 families interviewed during a preliminary survey, 49, were headed by females, 23 of whom had at one time been married but no longer had a spouse in the home, and 26 of whom had never been married.* The Coordinator feels that the absence of male figures who present positive attitudes and ideologies has contributed to the high regard many children have for drug pushers, who seem to represent a high degree of financial acumen.

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* These and subsequent data presented in this section are obtained from AC tabulations of completed needs assessments.

Of 144 persons interviewed, 128 reported Public Assistance as their main source of family income. Ninety-one of these persons reported being concerned about or having problems with Food Stamps.

The Coordinator explained one type of problem that exists concerning Food Stamps and Welfare. Food Stamps must be purchased, and in order to purchase them, the client is sent a Food Stamp Card. Very often the client has not budgeted her money carefully and when the card is received she does not have enough money to purchase her stamps. If she must pay $50 for $100 worth of stamps, but does not have the money, the local grocer will give her $10 worth of groceries in exchange for the Food Stamp Card. The grocer can then sell the card at a large profit.

The above is an indication not so much of problems with Welfare as it is a small insight into the survival techniques learned to handle problems on a short-term basis. It is an indication of crisis thinking as opposed to preventive thinking. Preventive measures would have involved learning to budget and this is a population that is, as The Coordinator puts it, "crisis-oriented." It is this "crisis orientation" that comes up time and again as a stumbling block to Advocacy efforts.

THE NEEDS ASSESSMENT

Prior to the writing of the Advocacy proposal and the construction of the needs assessment, the Parent Child Center (PCC) held Advocacy Workshops. Both heads of agencies and community residents attended those sessions and provided input into what the needs of the community were and what the Advocacy Component could do to help meet these needs. From persons at the Workshops came the names of the 56 families who completed needs assessments in the preliminary survey. Findings from these 56 interviews were tabulated and the results were used to modify the needs assessment forms and set program objectives.

After the preliminary survey, needs assessments were done through a door-to-door survey. When persons were not at home or when they refused to open the door, as did happen in a few instances, Advocacy workers slipped flyers under the door. These flyers provided information on what the Advocacy Component could do and how a person could contact the Component. In most cases, when persons were interviewed for the needs assessment, they were cooperative and spoke freely of their needs and concerns. This openness, so often not found by other programs, may have been a result of the manner in which the AC presented itself. Rather than try, at the outset, to explain "Advocacy," the AC workers introduced themselves as members of the Parent Child Center, which in fact they were. The Parent Child Center was an established force in the community and one that the residents respected. Whereas in some ACs, workers had to return to homes two and sometimes three times before they were able to get complete information, the Baltimore workers were able to get what they considered to be the necessary data on the first visit.

Use of data

The needs assessment did not really give the Advocacy staff any new information regarding the community, but it did serve other functions.

Data collected from the assessments was used by the Advocacy Component to re-evaluate and prioritize their original program objectives. Immunizations came up as a problem that could be worked on immediately. The many aspects of the housing problem were given high priority with the realization that total resolution of the problem would, of necessity, be a long-term, if not an impossible solution. The idea of training Resident Advocates seemed untenable as the information from the needs assessments began to take shape.

An important product of the needs assessment was the profile of problems that it drew. The Coordinator says that, "The agencies know what the problems are, but you can't argue without statistics." The needs assessment gives these statistics.

The Coordinator has given the information gathered from the assessments to the Department of Social Services and the Housing Department. He does not know, however, in what context they have used the data or whether it has been used at all.

RELATIONSHIPS WITH FAMILIES

The Baltimore Advocacy Component has now assessed one hundred and eighty-eight families. Once a needs assessment is completed the family is then considered an Advocacy family.

At this time workers are busy doing referrals for families on whom they have assessments and so a formal mechanism for maintaining contact with families for whom they are not making referrals has not been developed. However, because the catchment area is an apartment complex, the workers are highly visible and do have the opportunity to meet informally with families.

Persons in need of assistance have called or visited the Advocacy office. Often the persons who call are not AC families, but rather persons who have heard of the program. The Coordinator related an incident to point up the type of phone calls received. During the needs assessment phase, workers had knocked on the door of an apartment in Lafayette-Douglass. They heard noise from within, but the door was never opened. They returned a second time and this time they were told the woman didn't want to be interviewed. They slipped a flyer under the door and left. A short while later this woman called the workers for help. She was a young, unmarried woman, pregnant and addicted. She had been pregnant twice before. The first child was born addicted and had to go through withdrawal. The second baby died during childbirth. Now the woman was afraid of what might happen to her third child and so she called Advocacy. An AC staff member brought her to the hospital to undergo detoxification and then had her enrolled in the East Baltimore Medical Plan to receive pre-natal care.

This may not have been a typical phone call, but the illustration points up the visibility and availability of the Advocacy Component and, again, the prevalence of crisis thinking.

Referrals

The Coordinator estimates that perhaps 80% of all referrals have some specific outcome.

When asked what percentage of referrals are made by the AC but not carried out by families, the Coordinator's first answer was "too many." The number is actually about 25%.

The Coordinator does not see this as a function of the families he works with, but rather of the agency experiences they have had. "Ninety-nine percent of the families have come into contact with some social agency before, and it takes a long time to establish credibility. They've been promised too many things. They have jumped and there hasn't been anyone to catch them."

The problem of families missing appointments is one that is deleterious to staff morale. Workers have gone to families three, four and five times to see that one appointment is kept.

Despite this frustration the staff continues energetically.

Follow-up

Follow-up is made first with the client. The client is asked to either come see or call the Advocate Worker after each appointment. If the client does not visit nor call in, the Worker visits, or calls her. Agencies to which families are referred are also contacted as part of the follow-up process.

Case files are kept on every family. In addition, every Worker has an index card file in which cards are color coded by problems. This file is used for both referral and follow-up.

FAMILY GROUP PARTICIPATION

The Advocacy staff had originally planned to do a great deal more community organization than it now finds possible. The problem here is working with a population that is difficult to motivate, skeptical and, at times, afraid. Efforts have not at all been abandoned, but workers are beginning to realize that accomplishment must be seen in terms of a realistic time scale.

Mass meetings

The Advocacy Component, in conjunction with the PCC held a Hunger Meeting. During the meeting information was disseminated and a film, entitled "Hunger in Maryland," was shown. Materials for the program were supplied by the Maryland Food Committee, an organization concerned with the elimination of hunger and malnutrition. Their aim is to educate people to the food programs and services available to them and to work with agencies that see that people and programs are connected. Of the thirty families attending this meeting, twenty were Advocacy families, a turnout that pleased the AC staff.

The Component is planning to hold an interagency meeting sometime within the next two months. The meeting will provide another opportunity to reinforce agency coordination. Plans are also being formulated for a workshop for community people.

Information dispersal on a mass level is a subject that will be further discussed in the objectives.

Committees

No committees of Advocacy families have as yet been formed The AC staff has recently met with the Lafayette-Douglass Housing Department and Tenant Council in an effort to form a "Clean-up Committee," but this is still in the planning stages and it is too early to speak of any concrete developments.

Ongoing Groups

Group sessions for teenage mothers and pregnant teenagers are held once a week. At the time of the interview, the group had met five times and had grown in membership from an initial three women to the present nine participants.

The Teenage Mothers Club is presided over by the Component's Public Information Specialist who has earned two master's degrees, one in counseling and the other in special education. According to the Specialist and the Coordinator, teenagers' excitement and interest in the club has grown so that the club may branch out into several different areas. More detailed information on this aspect of the program will, again, be found in the discussion of objectives.

RELATIONSHIP WITH COMMUNITY RESOURCES

The Coordinator has said that the East Baltimore area is one of the "most social worked" areas known. Judging by the services available in the shopping center alone, one would not argue the point. The problem, in many cases, is not a lack of services, nor a lack of sensitivity on the part of the agencies, but a lack of funds and staff. The Coordinator feels that most agencies are aware of their responsibilities, but that they are constrained by the money and staff available in proportion to the number of people to b served.

Contractual agreements

Advocacy sees no reason for entering a formal contract with any agency. All the agencies contacted have committed themselves to help to the full extent of their respective capabilities.

Referrals from other agencies

The Welfare Department has referred one client to the Advocacy Component. The woman referred was a diabetic and had gone to Welfare to see if they could supply her with special foods she needed. Welfare could not help her and so they contacted the AC to ask if the workers knew of any appropriate agencies. The AC was able to make the necessary referrals.

St. Vincent's Catholic Organization, a charity group, also referred a family to the AC. The family was in need of money and shelter and the Organization was unable to provide assistance. The Advocacy Component, although also unable to provide all the help that was needed, did refer the family for emergency shelter.

The Principal of Schools 1 and 1a, schools for pregnant teenagers, provided the Advocacy Component with a list of girls they felt could use the AC's help. It was from this list that the Teenage Mothers Club was formed.

Ongoing meetings with other agencies

At the inception of the Advocacy program, The Coordinator was meeting with the Administrative staff of the Comprehensive Child Care Clinic (CCCC) every two weeks. The purpose of the meetings was to establish the basis of what the relationship between the clinic and the AC was to be. Two such meetings were held before the East Baltimore Medical Plan (EBMP) was assigned to take over the health care franchise for the catchment area. This meant that the clinic would only be serving the target population on an emergency basis and thus, it did not seem that ongoing meetings were vital to either the AC or the clinic. The Coordinator still maintains close contact with the clinic, but a greater thrust has been to develop a relationship with EBMP.

Although no regular, ongoing meetings with EBMP are scheduled, contact between the two organizations is frequent and close. The AC worked very closely with EBMP in an effort to register persons for coverage and continues to work with the agency to inform families of the services to which they are entitled.

The Coordinator and his staff also work extensively with the local Housing Department, but again the structure for meetings is not formal.

Agency coordination

As a result of some confusion, the Housing Department and the Department of Social Services (DSS) have been connected to each other in a new type of working relationship. Housing is planning a new program of social service. The Coordinator, not being sure of the kinds of referrals each agency would accept once Housing's program was initiated, met with the Department of Social Services. DSS was just as uncertain as the AC. In an effort to clarify the situation, the Coordinator called a meeting of the AC, the Housing Department and the Department of Social Services. The agencies continue to meet in order to work out an understanding.

It is the Coordinator's opinion that the proposed Housing program represents a duplication of service that will, in the long-run, provide less rather than more service to the target population. He has made his feelings known, but Housing continues its planning. This situation will be discussed further elsewhere in this report.

Changes in service delivery

Most of the agencies working within the East Baltimore area and serving residents of Lafayette-Douglass are government agencies. Because directives come from Washington, it is the Coordinator's feeling that changes at the agency level are really impossible to accomplish.

The heads of agencies are, for the most part, sensitive and cooperative, but they are constrained by limited funding and manpower. The concern of the AC staff then is not so much to change agencies as it is to get the services available from these agencies to the people. The gap is not in services but in the residents' knowledge of the particular existing services.

RELATIONSHIP OF AC TO PCC

The Coordinator characterizes the relationship between the Advocacy Component and the Parent Child Center as close. He is considered an Assistant Director of the PCC, in charge of the Advocacy Component, and is kept informed of and involved in all PCC events. The Policy Council is also involved in the Advocacy Component in that it makes suggestions to the AC regarding areas of Advocacy concern.

When needed, and by administrative decision, a PCC worker deals with an Advocacy family or vice versa. The relationship appears to be one of friendly cooperation.

OBJECTIVES

The following represents a listing of short-range objectives for the Baltimore Advocacy Component:

- Locate and assess needs of pregnant women and their families, assist with information, service referral and follow-through for both mothers and children.
- Special emphasis on teenage pregnancy.
- Information services to make parents aware of resources for children and, in particular, to develop a Consumer Resource Handbook.
- Housing problems.
- Encourage participation on Lafayette-Douglass Tenant Council.
- Develop a corps of Advocate Assistants.
- Staff training.

As was mentioned earlier, as a result of investigation of needs assessment data and increased experience in the community, some objectives have been given lower priority or have been re-evaluated as longer-term goals. Each objective will be discussed separately.

- Locate and assess needs of pregnant women and their families, assist with information, service referral and follow-through for both mothers and children.

Baltimore has some of the best hospitals, and health care facilities in the area are abundant. But the fact that care is available does not necessarily mean that full advantage of facilities is being taken.

The East Baltimore Medical Plan was set up with the help of Johns Hopkins and maintains a close working relationship with the hospital. It is a pre-paid program sponsored by the Federal Government. A member of the plan is enrolled for coverage for a minimum of six months. The enrollee's Medicaid card is stamped EBMP and he must use only the EBMP health center, except if specific service is not available at the health center or if this patient must be treated for an emergency. The East Baltimore Medical Plan offers a full-range of comprehensive care, including pre-natal care, and has an arrangement with Johns Hopkins Hospital that allows anyone receiving pre-natal treatment at EBMP to deliver at Johns Hopkins.

In terms of the objective, the Baltimore Advocacy Component did not find as many pregnant women as they had expected. The majority of the pregnant women identified were already enrolled in a pre-natal program. Those women located who were not receiving care, were enrolled by the AC staff in the East Baltimore Medical Plan.

A concerted and successful effort has been made by the Component's staff to enroll all persons not receiving proper medical care into the East Baltimore Medical Plan. This was a special thrust with families in which there were children under five years of age.

It was found from the needs assessment data that 58% of the children whose mothers were interviewed had either not been immunized or had not completed the immunization series. Thus, by enrolling families in EBMP, the AC workers have begun getting these children to the clinic for immunizations.

The staff has been able to further its efforts in the area of well-baby care through the assistance of the City Health Clinic. From the City Clinic, via the Comprehensive Clinic, the Advocacy Component receives a list of all newborn babies. If a mother on the list has already completed a needs assessment, the AC staff makes a referral for well-baby care. If not, Advocacy workers do an assessment and then work with the family.

The Component has made a great deal of health-related information available to the community through flyers, displays and information tables. Plans have been made for the AC staff to meet with the public relations staff at EBMP so that further joint efforts in health communication can be arranged.

- Special emphasis on teenage pregnancies.

As soon as a teenager in school is identified as pregnant, the School Board begins proceedings to transfer out of her regular school and into Schools 1 and 1a, the special school for pregnant teenagers.

Schools 1 and 1a present both disadvantages and advantages for its students. On the negative side is the "punishment" of being taken away from a familiar setting and familiar friends. This "ostracism" serves to reinforce the stigma of being young, unmarried and pregnant. However, the advantages of 1 and 1a are equally great. A student in these classes is enrolled in a prenatal care program and is given counseling as well as courses in maternal and child care.

While in 1 and 1a, the students receive much needed education, attention and care. However, once the woman delivers, her association with 1 and 1a is cut off. The school can provide no follow-up because of severe lack of resources and money. Funds are so tight that the Board of Education attempted to stop bus service to 1 and 1a. With insufficient money and staff, the school cannot check to see that babies are enrolled in well-baby clinics or that mothers are planning to return to school to finish their education.

The Teenage Mothers Club was formed to combat this lack of continuity and service.

The principal of 1 and 1a was instrumental in the establishment of the club. Concerned about the school's inability to follow-up on its students, she supplied the Advocacy Component with the names of seventeen (17) girls she thought would be interested in the club. Letters were sent to the girls inviting them to the first meeting.

Only three mothers came to this meeting. However, each successive meeting draws more participants. Referrals to the club are made by the teenagers themselves as well as the PCC and AC outreach workers.

The Component's Public Information Specialist chairs the meetings. There is no set structure to the meeting, rather it is a free-wheeling session during which any topic of interest to the members is discussed.

At the second meeting, the women decided that they would like to try to involve their boyfriends and husbands in the group. Realizing that it is difficult to interest men in maternal and child care, the AC staff is going to try to involve them "through the back door." AC workers will try to get tickets to basketball games or movies and use these preliminary group activities as an introduction.

At another meeting, the women agreed that it would be nice to have each meeting in another participant's home. This was a favorably met idea except that arguments now arise as to who should be allowed to host the next meeting. Everyone is so excited about inviting friends to their homes that they can't wait until it's their turn.

The women had mentioned that they were interested in learning how to sew, especially in how to make baby clothes. The Advocacy staff is exploring the possibility of obtaining sewing machines. If the machines could be obtained, the girls would be allowed to use them in their own homes.

It is the Coordinator's feeling that the teenagers are the real hope of the future for the community. They are the group that seems most anxious to improve conditions and are the most easily motivated. "They have not been in the poverty cycle long enough to lose hope." All of the participants in the program hope to be able to enroll their children in PCC, to finish school and to get jobs.

There is now the possibility that the Component will run two clubs. One would be for teenage mothers and mothers-to-be, and the other would be for teenagers.

- Information services to make parents aware of resources for children and, in particular, to develop a Consumer Resource Handbook.

The Consumer Resource Handbook is still being developed, although the Coordinator says it is now almost ready for printing. When distributed, it will be a most useful tool as the only guide now available costs $8.00 per copy and is unintelligible to anyone but agency personnel.

The Baltimore Advocacy Component has reached a large number of people through its information dissemination program. The Component set up a Drug Abuse Exhibit in the rental office of Lafayette-Douglass. The thrust of the exhibit was toward education. The AC felt that little could be done about the pushers and the addicts, but that they could do something about educating people to the drug problem. A wealth of printed information was dispersed and the Public Information Specialist, who counsels addicts, was available to answer questions. It is estimated that one hundred people stopped by the exhibit and left with some kind of information.

Another such project was arranged in the rental office. This time the aim was to provide information on Advocacy and other available community resources. The information table was in the rental office on the day that rents were due. As a result, some two hundred persons were reached. It has since been decided that the Component would set up such an information dissemination table every month on rent day.

In addition to dispensing information, the Advocacy workers also supply their families with vitamins for both parents and children. These are an in-kind contribution from Miles Laboratories.

- Housing problems.

Mice, roaches, uncovered radiator pipes, drugs, urine-stained elevators, no recreational facilities, no police protection, cement floors, poor garbage disposal systems - the list of housing concerns of the residents of Lafayette-Douglass goes on and on.

The Coordinator and the Housing Department personnel have developed a cooperative relationship, but the Coordinator feels that to work on these problems, the community must be allowed the loudest voice. Both the housing managers and the AC Coordinator have been working together to create a forum for community action, a coalition that would include community residents and that would be able to act to prevent housing problems. The coalition is slow in forming, residents are not certain that they can work with Housing, they are not certain that they can effect any changes. Motivation is the problem, but the Coordinator feels that they can get people together.

The staff has managed to initiate a letter-writing campaign. All letters written to the Housing Department are delivered to the housing managers by the Advocacy Coordinator. The housing managers may know what the problems are, but the letters let them know that the community is also aware.

Letters were written about the uncovered radiator pipes on which children are incessantly burning themselves as they play. Letters were also written about the "mouse pads." Mouse pads are Housing's low-cost solution to the rodent problem.

They are sheets of paper, the thickness of oak tag, that are covered with a sticky, non-toxic substance. A mouse, stepping on one of these pads will not be able to move. The principle is like that of fly paper. Because the glue is non-toxic, it will not kill the mouse, just render it immobile. It takes three or four days for a mouse to die of starvation and during that time it wiggles around on the paper and squeaks and squeals so that the children are awakened in the night. Women are afraid to go near the pads when the mice are still alive and so only dispose of the papers when the wiggling and squeaking have stopped.

Nobody, of course, likes the mice and everybody hates the mouse pads, but people seem to think that they are just another burden that must be tolerated. The Coordinator wants to teach the people that the mice and roaches are not just unpleasant, they are unhealthy. He is planning to obtain slides and information brochures from the Health Department. He feels that if he can make the residents aware of the health hazard they may be further motivated to join in the coalition to help prevent these problems.

The Coordinator knows that if he calls the Housing Department downtown he can get instantaneous action, but this is a short-term solution. The longer-term solution is for the community to act; for them to be interested and self-sufficient enough to work on their own problems with assistance from other concerned groups, such as the AC, when needed. Efforts are being made in this direction. An attempt is going to be made to create community pressure so that if a person refuses to have his apartment sprayed for roaches, community pressure will force him to do so. This is not an easy task.

Getting the community together to press for police protection is an even harder task. As was mentioned earlier, it is estimated that 50% of the tenants in Lafayette-Douglass are involved with drugs. The problem is that if the other 50% call for police protection and report the junkies and pushers, they have to be afraid of what the reprisals from their neighbors would be.

The Coordinator does not want to become known as a troublemaker. He does not want police protection of the area to come about because he, Child Advocate Coordinator, has publicized the problem to the community or the authorities. He feels that if he were to do this, his Outreach Workers would no longer be able to live and work in the community and the Advocacy Component could no longer be a viable force in the neighborhood.

He has, however, approached the Police Department on the matter of their setting up a Police Department Community Relations Storefront in the area. The Department claimed that there already was such a storefront in the neighborhood. This is in fact true. There is a Police Department Storefront in the neighborhood, but it is several blocks from Lafayette-Douglass and too inconvenient for use by the project's residents.

- Encourage participation in Lafayette-Douglass Tenant Council.

Lafayette-Douglass has both a Tenant Council and Resident Advisory Board that meet once a month. Of 144 persons interviewed, 28 claimed to attend tenant meetings. Neither group is at all respected by most residents.

When asked why they don't attend tenant meetings, some typical responses from the residents were, "it's a waste of time," "too much confusion," "the group doesn't follow-through on anything," "nothing seems to change."

Even PCC staff members who live in Lafayette-Douglass will not go to meetings because they also feel that it is doing nothing.

An Advocate Assistant who lives in the project does attend Tenant Council meetings. She notifies persons of upcoming meetings and encourages their participation. No one ever attends.

The local Housing Department has written a proposal for a new program that would allow them to deliver total family social services to residents of Lafayette-Douglass. Housing is hoping that this project will restore tenants' faith in the Department. They hope to erase their poor image by hiring residents to work on the program. Two questions are presented by this proposal. First, knowing residents' poor response to participation in Tenant Council, how is Housing going to recruit people for their project? Second, knowing the types of tenants in Lafayette-Douglass and the image of Housing,isn't it possible that persons working for Housing will soon lose their friends in the building?

The responses to the proposed project are interesting sidelights. The Coordinator does not understand why Housing is going into this venture. His feeling is that they have so many problems in the area of housing itself that they should not be breaking into a new area in which they have no experience nor expertise. In addition, the Department of Social Services has said that if Housing's project goes through, they, the DSS, will do nothing for persons in Lafayette-Douglass, but send them their checks.

- Develop a corps of Advocate Assistants.

This objective was originally meant to refer to a corps of Resident Advocate Assistants. That is, people who lived in Lafayette-Douglass who would be trained as Advocacy Assistants so that they could be called upon at night when the regular AC staff was not available. According to the Coordinator, this idea has since been abandoned for several reasons. First, it would take a "rare and special" person who would allow neighbors to call on him at anytime during the night. Second, judging from the response to Tenant Council, it is difficult to imagine that persons would be interested in the position. If such persons were found, it is doubtful that they would accept positions as volunteers with no salaries. Third, even if requirements one and two were met, training would be a problem. The Advocacy Coordinator spent two and one-half months organizing and training his staff. There would not be sufficient time for the Component to completely train Resident Advocates.

It is now The Coordinator's opinion that if the AC can disseminate enough information and reach enough people, neighbors will be able to help one another.

- Staff training.

Since the inception of the program, the Component has been paying an outside consultant to run training sessions. All-day sessions are held once a month. The consultant is trained in administration, law and social work, and works with the AC staff on both an individual and a group basis.

A week or so before each session, the consultant sends everyone on the staff training material to be read. In this way, the staff is well prepared for the meeting. During group sessions, the consultant delivers a lecture and then provides ample time for questions and answers. Individual sessions take two forms. The consultant always asks the staff to voice their concerns or problems. She meets with any staff member who wishes to discuss any problem. In addition, if the Coordinator feels that a staff member is weak, or needs assistance in a particular area, he informs the consultant who sets aside time to work individually with this person.

The Coordinator conducts weekly staff meetings during which general problems and plans for the Component are discussed. In addition to weekly meetings, the Coordinator spends approximately one-half hour each day meeting with his entire staff to learn what has been done and what is planned for the day. He is aware of most of the cases with which his workers are dealing as he meets individually with each Advocate to discuss their files.

Summary

The catchment area and target population of the Baltimore Advocacy Component present special problems that make goal achievement difficult. The Lafayette-Douglass Housing Project contains within its bounds so many of the most critical urban problems that solutions, or even improvements, do not come immediately.

Progress is being made. Families have been enrolled for medical coverage, teenagers are meeting together, information is being disseminated and the roots of community mobilization are beginning to take shape. On the agency level, contacts have been made and working relationships developed. The frustration is not that too little has been done, it is that so much remains to be done.

STAFF

Organization and background

The Coordinator is thoroughly familiar with the problems of the area as he spent his youth in East Baltimore. After finishing college and attending law school he has returned to work with the people and the neighborhood that he knows so well. He refers to his situation as, "the return of the native."

The Public Information Specialist, with M.A.'s in counseling and special education, was originally responsible for developing the Consumer Resource Handbook, locating and informing agencies about the Component, and providing information to the community and the media. She is doing all of this and more. The Public Information Specialist has become involved in the Teenage Mothers Club and drug education. In addition to her responsibilities at the Component, she also counsels at an addiction program and teaches part-time at Antioch College.

The three (3) Advocacy Assistants are responsible for home visits and referrals. They are community people who are most knowledgeable about the problems of the area. One worker previously lived in Lafayette-Douglass and one presently lives there. In terms of background, one Assistant had been a volunteer in the community, one had been an assistant teacher at the PCC, and for one this is her first job.

Staff relations at this Component seem to be open and friendly. There is a great deal of communication between staff, and between staff and Coordinator.

Training

Training has been discussed under objectives.

Staff turnover

Since the AC's inception, two staff members have left the program. The Group Family Worker resigned when she was offered a teaching position that she felt would provide her with a better opportunity. Her position has not as yet been filled, although an additional Advocacy Assistant was hired. One secretary was terminated and a replacement for her position has been hired.

CASE STUDY SEPTEMBER, 1972

ADVOCACY COMPONENT
OF THE
BOSTON PARENT-CHILD CENTER

Principal Author: Bruce H. Carrier, Ph.D.

BOSTON, MASSACHUSETTS

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BOSTON

FAMILY CONTACT SUMMARY [1]

Number of different families telephoned for reason other than to schedule a home visit	177 [2]
Total telephone calls to families, May through September	373
Number of different families visited in the home	229 [2]
Total home visits to families, May through September	459
Number of needs assessments completed prior to May	147
Number of needs assessments completed since May	68
Total number of families dropping from "participation"	37

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[1] For period of May through September, 1972, inclusive.

[2] Total of monthly figures of different families contacted.

BOSTON

REPORT OF REFERRALS[1]

	Numbers
MEDICAL REFERRALS	
ALL MEDICAL (sub total)	53
PERCENT OF TOTAL REFERRALS	(27)
Prenatal care	3
Neonatal care	1
Nutrition	
Immunization	
Check-up	[illegible] [2]
Medical coverage enrollment	
Hospitalization	[illegible]
Surgery	
First aid	1
Medical appliance	
Family planning	[illegible]
Eye examination	1
Hearing problem	
Speech problem	
Dental examination	1
Dental problem	16
Medical miscellaneous	3

	Numbers
PSYCHOLOGICAL REFERRALS	
ALL PSYCHOLOGICAL (sub total)	4
PERCENT OF TOTAL REFERRALS	(2)
Psychological testing	
Retardation	1
Psychiatric care	2
Developmental/behavioral problem	1
Psychological miscellaneous	

	Numbers
EDUCATIONAL REFERRALS	
ALL EDUCATIONAL (sub total)	26
PERCENT OF TOTAL REFERRALS	(13)
Adult basic education	9
Private/special school enrollment	7
Facilitating transportation	1
College or equivalent enrollment	
Head Start enrollment	6
Educational miscellaneous	3

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[1] Totals reported for June through September, inclusive.

[2] Immunizations were given as part of enrollment in some cases.

BOSTON

EMPLOYMENT-RELATED REFERRALS

	Numbers
ALL EMPLOYMENT (sub total)	21
PERCENT OF TOTAL REFERRALS	(11)
Job rehabilitation	
Job training	6
Job placement	15
Employment miscellaneous	

HOUSING REFERRALS

ALL HOUSING (sub total)	29
PERCENT OF TOTAL REFERRALS	(14)
Home repair/improvements	5
Furniture/appliances	1
Relocation (ruined quarters)	8
Relocation (more space)	10
Rent payment	2
Eviction	2
Housing loan	
Pest control	
Housing miscellaneous	1

WELFARE REFERRALS

ALL WELFARE (sub total)	7
PERCENT OF TOTAL REFERRALS	(4)
Food stamps	
Special welfare services	1
Increased welfare payment	2
Welfare enrollment	1
Veterans Admin./Social Security	1
Welfare miscellaneous	2

MISCELLANEOUS REFERRALS

ALL MISCELLANEOUS (sub total)	58
PERCENT OF TOTAL REFERRALS	(29)
Help obtain clothing	
PCC referral for enrollment	6
Legal problem	2
General transportation	1
Day care	34
Baby sitting	4
Help obtain emergency food	
General information/miscellaneous	11

TOTAL NUMBER OF RESOURCE CONTACTS	198 (100)

THE COMMUNITY

The catchment area

The Boston Advocacy Component is unique among the four urban AC's in that it shares its quarters with its Parent-Child Center. The PCC has moved within the year from a former settlement house in Roxbury to a commercial facility in North Dorchester. The PCC and its AC now occupy most of the space available on the second floor of a sizable AVCO printing and publishing plant.

AVCO is one of few corporations to make a deliberate commitment to provide jobs in the ghetto by themselves moving into the ghetto. Additionally, the firm provides early childhood education for residents through the day care center which shares the second story with PCC/AC. That center, originally instituted to serve employees' families, has evolved into an independent facility, with its own kitchen providing meals for the PCC as well.

Thus, the Advocacy Component has the advantage of being near the heart of its catchment area, of staff members working side-by-side with PCC staff members, of the availability of further child care resources, and of comfortable, wood-paneled, carpeted surroundings.

The Boston Advocacy Component's catchment area is one of six sub-areas defined for the Boston Model Cities program. Sub-area #5, the AC area, includes a substantial portion of the southeastern metropolitan area -- in the populous Roxbury and North Dorchester sections. Problems are manifold: drugs, crime, overcrowded educational facilities, and frequently substandard housing conditions. There are hostilities or suspicions among ethnic groupings and toward those controlling public resources. Inertia and distrust are major factors which complicate the AC's work.

Single- or small multiple-family houses predominate in the catchment area. Along Geneva Avenue, the site of the component, one sees mostly two- and three-floor houses with yard areas all around. There is no public housing at all and all apartments are low-rise. The streets are dotted with trees as in suburban locales. Many houses are in need of paint or woodwork repairs and one building in six is vacant within the Model Cities boundary.

The target population

From Census data, it is estimated that 11,560 persons live within sub-area #5: Of these, 92% are black and 7% are Spanish-speaking peoples. The only other groups broken out from the remaining percent are oriental and east Indian.

Almost one person in six has no health insurance at all, while another one in four receives Medicaid assistance. Almost one resident in four (23.6%) has been diagnosed to be suffering from lead poisoning. A consistent finding is the infant mortality rate -- 41.4 per thousand births in the Model Cities area versus 21.7 for the city in its entirety.

Census data have not broken out children 5 years of age or younger. However, they do list 1,525 aged 4 years or younger and another 1,514 between ages 5 and 9. Thus, there are probably slightly more than 1,800 target-age children within the area. Figures from Boston City Hospital show that the live birth rate has leveled off and even begun to decline a bit during the last three years.

The modal age of mothers at time of delivery has declined. In 1969, the modal category was ages 15 to 19. Now it is the under-15 category, among whom live births have doubled in the interim. The implications with respect to need for prenatal information and medical attention among girls in their early teens are quite clear.

Forty percent of the households in the catchment area have reported annual incomes of $5,100 or less. Since the average family size is 3.4 persons and the poverty level demarcation is approximately $3,800 for a family of four, it is estimated that close to a third of the catchment homes are below the poverty level. Three in 10 receive welfare assistance, slightly more than that (31.5%) have no telephone, and unemployment is at 10.9% versus 6.2% for all of Boston. That 10.9% does not include any of a substantial portion in an additional 18.5% for whom no occupation is listed because they are not looking for jobs. These latter are not classified as unemployed.

NEEDS ASSESSMENT

As of September 15, 1972, the ten AC staff members had made a total of 3,173 attempted house calls. The result has been 321 positive contacts, 215 completed assessment questionnaires, and a host of fruitless visits and revisits. Some of the contacts were referrals made by administrators of other agencies. The greater part of the contacts were accomplished as a part of the door-to-door effort.

Problems

The frustration of being able to obtain completed interviews with only 10% of the population initially contacted speaks for itself. Families are resistive to new programs. As the Coordinator indicated, "people whose problems are so multiple and for whom survival is a major concern, are not easily persuaded nor naturally interested in participating in any kind of survey with which they are not familiar." This is a problem that was encountered by other component staffs as well. Families have been disappointed too often to become optimistic when a new program is offered.

The needs assessment experience pointed up the difficulties of inducing needy families to accept AC intervention and to utilize resources. Although disappointed that families did not respond immediately and positively to the Advocacy concept, the staff was aware of the attitudes of the population they would be serving and knew that a mere recital of opportunities would not produce participation. The process of establishing confidence in the AC would require constant reinforcement.

Thus, the AC had adopted a low profile with potential clients when it comes to describing Advocacy and the prospects for improvement of living conditions. The AC's course has been to initiate discussions by merely stating Advocacy's intention in the most fundamental possible terms -- that it is people trying to be friendly with and helpful to others like themselves, that there is no magic in which might happen, that the staff recognizes "the situation" in Boston. From that point onward that AC staff works toward making things as easy as possible for parents to get interested. The approach is always tailored to avoid suspicion and disbelief.

The needs assessment survey was seen to be more useful in terms of the information gathered, than as a means to gain entré to families. Knowing that families tended to be distrustful of publicly-funded programs and that they did not like to feel as though they were being studied, AC staff members did not carry a large questionnaire and check off answers in front of those interviewed. It was felt that an overt surveying technique would only impede the development of rapport with families.

Information gathered

Questionnaire items cover a variety of specific topics pertaining to health, education, and welfare needs, as well as a standard set of demographic items.

Use of the data

The information gathered has already led to some direct program steps. For example, the need for better beds and for dental care are being addressed, as these needs were identified through the needs assessment. Activities in both areas represent modifications in the AC's original plan. The AC approached its local welfare office, a "demonstration" project which is experimenting with new streamlined procedures, with requests for more sizable and better constructed beds. It turned out that beds were not obtainable in this fashion; consequently the AC is trying to organize a program among fathers to refinish disused beds -- an activity that may, if it gets going properly, serve three purposes: (1) involving men, (2) affording a sense of self-reliance among families and (3) providing better beds.

The pervasiveness of dental needs has moved this aspect up on the list of Boston AC priorities. An arrangement has been made through the Boston University School of Dentistry to make professional dental services available to catchment families.

A less tangible but perhaps much more important benefit of the needs assessment has been to establish the AC in the eyes of other community agencies. In her talks with resource leaders, the Coordinator has found that administrators are favorably impressed by the fact that AC has already done a lot of legwork in going out to document the nature of catchment area needs. Several agencies have already asked that items be included in the questionnaire pertaining to their areas of operation.

RELATIONSHIPS WITH FAMILIES

The Boston Advocacy Component has adopted a standard approach to maintaining family contacts. Virtually all of the 215 families involved in the needs assessment are visited in their homes periodically. Periodicity may range from monthly in some cases, up to weekly or more, depending on receptivity and circumstances of need--immediacy, multiplicity, availability of resource, etc.

Regular telephone calls (exclusive of ones made to set up appointments for home visits or referral) are placed to approximately half the families, usually on a weekly basis. Staff workers estimate that approximately 25% -- perhaps a bit fewer -- of the families have called *them* with a problem or request.

Reflective of the "wait-and-see" attitude in this community, the Component has had to demonstrate its good intentions and its effective record at every point along the way. Even so, the Co-ordinator feels that many of the people drawn in thus far may be those with needs more easily soluble or visible. The ones who could use Advocacy the most tend to remain resistive or hidden.

Referrals

Two specific examples will point up the in-between stage reached by the Boston AC in concrete activities. One is the program of dental care which has already been mentioned. When the dimension of the problem became known, a linkage was established with an area professional group, through the offices of the Director of Boston

University's School of Dentistry. The agreement was that free dental services would be provided target families by dentists in a well-equipped central location within reach of the catchment area.

Initially, 50 appointments were made and confirmed with families over the telephone. The turnout was dismal. The dentists became angry about "dinkies" (from the acronym D.N.C. for "did not come") because of the loss of professional office time. AC staff members investigated the situation and uncovered two reasons for the poor showing. First, prospective patients did not know how to get to the offices or were confused about what to do if they did. Secondly, clients shared the very common belief that dentists hurt, so why go unless there is a problem that requires immediate attention. This was an indication of the prevalence of "crisis thinking." Preventive care is not given a high priority when many other, more immediate problems exist.

The Coordinator worked up a set of directions, covering surface routes, which way to turn upon leaving the elevator, and what to say to the receptionist. An attempt was made to convince families that their crisis orientation contributed to making the dentist office a painful experience, that prevention was different from cure. Twelve more appointments were scheduled, and exactly one person showed up this time. The dentists became more irate.

The program has been continued with those dentists who were willing to go along, but the problem of "dinkies" has also continued.

The AC cannot physically take patients to the dentists, and what might have been a greatly successful resource remains -- for the time being -- just a resource in search of users.

The other example offers more cause for optimism. A log of 41 pregnant women has been developed, and very early in AC operations last spring a weekly "class" for these women was instituted at the AC's offices under the guidance of the AC Health Team Leader. At the start, and for a long time thereafter, the class was more like a tutorial because an average of only two participants would arrive. Pediatricians came to speak, the Team Leader prepared agendas, but sometimes nobody showed up at all. Then, suddenly, on the second day of this writer's visit, the session drew 13 participants. A film was being shown that day, and it lead to an animated discussion. The women got to know each other and Advocacy.

Planning for subsequent sessions is now proceeding apace. A nutritionist has been recruited, and the Coordinator feels that tying nutrition into pregnancy with concrete examples and suggestions from a professional will make the whole topic of proper food more real.

These are examples of referral activity stemming from different perceptions by participants of their own needs. The parents did not perceive any pressing dental needs although many reported dental service as something they lacked. Need was more apparent to the pregnant women. Yet programs instituted in both areas started off relatively unsuccessfully. The point to be made again, this time with respect to the referral process itself, is that needs must be made to appear very real to the persons who presumably have them before legitimate hope may be held for achieving solutions.

Boston's overall approach to referrals has been to seek solutions to whatever family problems are encountered, rather than to focus on a few areas of high priority needs. The Coordinator feels that the problems in a family are usually interrelated and that by treating needs as a gestalt, a better understanding and resolution may be achieved for the family.

The process of referral has been changed at the Boston AC since the Component's inception. Originally, after the period of outreach worker orientation which consisted of closely supervised home visits by Team Leaders and the Coordinator, team members made referrals immediately after assessing needs. That is, they would look at the problems encountered, drop in effect, everything else and pursue the needs of that family (sometimes while still in the home) before going on to the next.

Although workers still make some referrals "on the spot," they have been asked to bring cases, in specific areas, back to the Team Leaders. In this way, a group of cases requiring contact or referral to the same agency can be handled together. The Coordinator presents the following illustration as an example of how this process economizes on time and produces a greater impact: "One Education Advocate calling a day care center for five places for referrals, from the whole Component, not only saves time, but demonstrates to that day care center the quantity of business Advocacy is doing."

Follow up

Standard practice has been to make appointments for participant families with local resources, to remind the families of their commitments, and to check back to each family after time of referral. Careful in-office review of needs and referrals has come to include as a matter of course the planning and monitoring by Team Leaders of follow-up. The matter of outreach workers who have had difficulties in this aspect is a problem that will be discussed in the section on staff.

Multi-problem families

The Coordinator believes that '*All* catchment area families are multi-problem families, even the ones who have incomes that should put them out of our range. With crime being what it is, everybody is afraid. When your neighbors are all suffering, you are. Anyone living in the inner city is subject to the reduction of quality public services and the consequences of deprivation of his residence and must be considered high-risk."

When asked to think of a case she would term truly multi-problem, the Coordinator and her Education Team Leader did describe one that strongly typifies this classification along traditional lines of definition. There is a 23-year-old woman whom the AC has contacted who gave birth to twins. During the mother's prenatal period she looked unduly large, so the hospital performed a B-scan (a sonic substitute for an X-ray) which indicated a single birth. During delivery, the obstetrician was looking for only one child and did not notice the second until it was oxygen deprived.

The child is brain damaged. The mother has had mental health problems which were exacerbated by the delivery. Her welfare assistance is inadequate. The child may die, and yet the mother insists on taking him home from the hospital. The mother's sister, who lives across the hall from her in an apartment building, keeps telling her that she is right in what she wants to do. The AC has been working with the mother to convince her to leave the child in intensive care but both they and the hospital staff are powerless to stop the woman if she carries out her wish.

FAMILY GROUP PARTICIPATION

There have been enough difficulties at the Boston AC in gaining individual family interest to preclude any great concern about having numbers of families come together. However, attempts have been made on a regular basis.

Mass meetings

There are regularly scheduled Monday-afternoon open sessions to which all 215 families have been invited. The usual attendance figure hovers between 10 and 12.

These meetings are moderated by Team Leaders, often with invited community speakers or participants, organized around a different topic each week. The health, education, and welfare Team Leaders alternate in the chair each week. Having learned a lesson about making participation as easy as possible, fliers announcing each session make much of the fact that the whole family is invited -- children and all (babysitters are made available at the PCC).

The sessions have been useful in that a few families from disparate parts of the community have become acquainted with each other, and in that some information about Advocacy and about particular discussion topics has been transmitted. However, there is an overlap among the families who attend and there is a definite desire on the part of the AC to broaden the appeal of these meetings.

Committees

No committees have been formed to date.

Groups

The pre-natal group already described is the primary example in this category. Its recent success has reopened the prospect of gathering groups for specific purposes.

RELATIONSHIP WITH COMMUNITY RESOURCES

The Coordinator spends a great part of her time in the establishment of linkages with and among community agencies.

As a first step in establishing Advocacy, the Coordinator paid a considerable number of "courtesy calls" to the administrative Directors of major resources serving the catchment area. Starting with a few Directors and Commissioners, she has expanded her contacts on the basis of recommendations from the first people with whom she spoke.

The general pattern has been for her to introduce herself, explain the overall aims and approaches of Advocacy, and discuss broad ways in which she and each agency might cooperate. She also obtained introductions to second-line agency personnel with whom she and her Team Leaders continue to talk on a relatively frequent basis. Contact has been maintained with agency leaders through their participation on an advisory board of the AC.

Substantive discussion of specific topics has continued with the middle-level resource people, and in several cases, already has led to developed formulas of collaboration. When that point is reached, a plan is then brought to the highest echelon for review, comment, and a go-ahead decision.

The Boston AC has apparently been successful in establishing working relationships critical to the attainment of major objectives. In most cases, relationships have been founded on the concept that cooperation is a two-way street. The basic idea here is that before the AC asks an agency to provide or improve a service, there should be something that the Advocacy staff can offer in return. Reciprocity seems to take three essential forms at present: active outreach on behalf of an agency by serving as an extended arm to bring in more patients or clients for that agency; passive outreach in the sense of serving as an information dissemination unit to publicize the function of a resource; acting as a training ground (mainly for educational institutions) by providing, along with the PCC, a locus at which those learning can gain on-the-line experience.

Two sessions with resource people were observed at the AC. Each was instructive in terms of the style adopted by AC staff in approaching the problem and in terms of the reciprocity offered.

The first meeting was attended by a psychiatrist from the Roxbury Health Center (RCCHC), the Education Team Leader of the AC, and the Coordinator. At issue was the prospect of RCCHC providing diagnosis and counseling for emotionally disturbed children in the area public schools. The problem is that most school administrators seem unable or unwilling to view even the most egregious misbehavior in terms of psychosocial deficit. Younger, more liberal teachers may be receptive to the idea that a counseling program would be worthwhile, but older ones are apparently quite resistive to psychiatry *per se*. Any frontal, direct attempt to win approval might polarize faculties and put acceptance beyond reach.

The psychiatrist stated her desire to gain entry to the schools, the dimension of need was discussed, and then consideration passed quickly to alternative plans for getting into the schools. Boston's public school system has traditionally been extremely negative to any but the most traditional methods in education. Hence, any idea of going to city-wide administrators was quickly discarded. Then, too, it was agreed that any broad information campaign might heighten the negativism of too many who are opposed to psychiatry in any form. This consideration also tended to rule out any direct, visible participation by RCCHC, at least, initially.

It was eventually decided that the AC could use its reputation as an indigenous group who knows the community, thereby befriending a core of parents to convince them of the possible desirability of such a program. As part of the same approach, the AC would talk to school personnel about AC and, if the ground seemed fertile, mention casually the concept of trying some kind of counseling program. If they got a nibble, the idea would be to say something along the line of: "It just so happens we know some people who could help." Then RCCHC could take a hand.

In this case, the AC's part of a collaborative bargain with an agency was in essence simply the "lending" of their assumed greater degree of acceptance than that of the agency. The AC would, in effect, run interference for the agency while performing their (the AC's) normal contact and outreach function. It is also interesting to note that in trying to form a linkage for the AC, they would also be forming a linkage between two resources -- the health center and public schools.

The other meeting concerned the possible creation of a degree curriculum in Child Advocacy at an area school. Present with the Coordinator were the administrator and a faculty member of Wheelock College, a small institution specializing in early childhood education.

After considerable time spent by the Wheelock people in obtaining more specific information about what the AC is doing, the conversation came down to who could do what for whom, and when.

It was agreed that progress would best be achieved slowly. From the AC side, it was felt that the Coordinator could lecture at the college (she already has) and that the AC might afford some placements for field training of a few Wheelock volunteers. Although nothing was definitively arranged at the meeting, one of the reciprocal benefits offered to the college (placement of volunteers) is, of course, a strong benefit for the AC.

It is also interesting to note that, just as the Boston AC had adopted a very low pressure approach in contacting families, they have found it wise to go slowly and easily with resource organizations.

Contractual agreements

There are no formal contractual arrangements in Boston as yet, and there may never be any. However, several agreements in writing have been obtained. Letters of general intent, which these are, may not be legally binding, but they do represent statements of commitment in good faith which are morally binding. As such, the process of obtaining them is important and will be described.

° RCCHC: The agreement is that training sessions will be held at the health center so that AC outreach workers may become familiar with the center's registration and screening methods. AC staff are then to act as official RCCHC outreach workers and may enroll people directly, without merely passing them on to the center. The formal process began when the entire AC staff went to the health center to meet with several of the administrators. Following this, AC Team Leaders met with their appropriate counterparts at RCCHC and an agreement was reached to "get together in an old-fashioned case conference to discuss who would make the primary thrust to families served in common." From those meetings came the plan for, and eventual administrative approval of, formal training and official RCCHC outreach status for AC workers.

° MODEL CITIES: The agreement is that Model Cities' data processing wing will transfer all needs assessment questionnaire data to IBM code sheets, punch the data, produce tables and store all data for rapid retrieval/computation/display. This is to be done once 500 cases have been amassed and the AC had coded the data.

° BOSTON UNIVERSITY CENTER FOR APPLIED SOCIAL SCIENCE: The agreement is to provide training sessions for outreach workers in investigative techniques and to make available the services of graduate Fellows to assist at the AC. Three such Fellows are now working part-time at the Component. Training sessions will continue until the outreach workers seem to have mastered the art of interviewing. To obtain this arrangement, the Coordinator first went to the Dean of the BU law school in search of legal assistance. The Dean said that he could not assign a person as legal advisor to the AC because his faculty (unlike those of many medical schools) would not "sit still for it." Instead, he referred her to the Director of the Center for Applied Social Science who saw the connection between his operation and that of the AC and immediately assigned a lieutenant to arrange some training sessions. That man, who has since left to head all of the state of New Hampshire's Advocacy efforts, wrote papers and proposals for the AC as well as planning and making operational the training program.

- HEAD START: The agreement is that all children recruited by the AC, whose parents desire so, will automatically be enrolled at the Hilltop Head Start facility in Boston, if a vacancy exists. The Coordinator made an initial call on the head of Action for Boston Community Development (ABCD), the PCC grantee. That individual introduced her to each of his departments in turn, one of which is Head Start. The Coordinator then referred the Component's Education Advocate to the Head Start Director who, after a meeting, wrote an agreement that Hilltop Head Start would be the AC's official linkage.

Referrals from other agencies

When a few scattered referrals from disparate sources are omitted, the result is an approximate total of 54 referrals from four community services: Children's Hospital Medical Center (6), RCCHC (21), Harvard Street Health Clinic (15), and Grove Hall Demonstration Welfare Project (12).

The majority of the above cases have been referred to the AC for one or both of two basic reasons:

- The resource finds more problems in the family than that agency can address, by the limited nature of their competence or charge. This occurs, for example, when a medical facility finds a family in dire economic straits or when the welfare office finds a family with psychiatric problems. The AC is used as a clearinghouse in this sense.

- The agency encounters a family it believes might be enrolled at the PCC. Many of these cases (not counted in the above tabulation) turn out to be families in fact not qualified for PCC, for various reasons (economic circumstances or age of children). When a qualified case is found, the AC acts as a PCC recruiter.

Additionally, there are two lesser reasons for referral -- lesser in terms of frequency encountered so far:

- The agency learns of a case appropriate to its function, but one in which it has no jurisdiction. Occasionally, a resource hears of a family with a need, but they are not supposed to make contact (out of catchment area, already being handled by another facility, etc.). The agency will ask the AC to bring that family in, whereupon they cannot be expected to refuse service. In such instances, the AC acts as a kind of at-large, ingenuous go-between.

- An agency may fear "complications" in a case they are treating. They ask the AC to keep an eye on the family because the agency cannot do so to the degree that AC can. This would be a monitoring activity for the Component.

The number of incoming referrals to AC has not been great in the absolute sense, but it has already uncovered some of the ways in which AC can be of service to both target families and agencies, whose help is in turn sought by the AC.

Ongoing meetings with other agencies

These take two forms, varying in level more than in topic area. One meeting group is the Professional Advisory Board which is composed of agency administrators and public officials. The other is the Ad Hoc Committee which draws middle-level project people and administrators.

At last count, 47 prominent leaders have stated their desire to be associated with the Advisory Board. Some seem to approach participation in an honorary capacity. More, though, seem to hold the promise of actual involvement, if they have not already been involved. Two meetings have already been held, the first of which -- the AC's so-called "big splash" earlier in the year -- drew a considerable attendance. The Associate Director of the Children's Bureau, Office of Child Development, gave the keynote speech.

The more recent meeting drew an attendance including, among others, the head of Model Cities, the State Commissioner of Welfare, and a representative of the Superintendent of Boston Public Schools. Progress so far has primarily involved the process of acquaintance among directors, commissioners, deans, and planners who may have known each other only by name prior to the session. However, the Coordinator's goal is to form special action subgroups or committees of the Board to deal with specific problem areas.

Ad Hoc Committee meetings are less formal than those of the Advisory Board. There are three Ad Hoc Committees, one each for the areas of health, education, and welfare. The Ad Hoc group brings people from resources serving the catchment area directly into the AC every two weeks. The committee members see themselves as an action group working to make an impact on policies. In addition, the Committees serve as a vehicle for information transmission.

The AC Team Leaders have the responsibility of planning the agenda for their particular Committee, inviting guests, and chairing the sessions, all with the Coordinator's supervision. Resource people are often asked to do most of the speaking, although the Team Leaders sometimes choose to lead a general discussion. A recently-held session was comprised of the AC staff and representatives of the Grove Hall Demonstration Welfare Project, Boston Health and Hospitals Day Care Licensing Unit, and the Roxbury Multi-Service Center. This last is another service conglomerate, which provided the day's speaker -- a young man who was eminently well informed about the city's and commonwealth's penal system. He talked at length about prison conditions, child support laws, court tactics, reform, and administrative policies. Questioning was brisk and there was a time for general announcements at the end (a City Hall hearing scheduled for that evening, a newspaper article that should be read, etc.).

Although little tangible result has come from the intercommunication gathered by the Ad Hoc groups, one semi-abortive project did get underway. At the very first meeting of the Health Ad Hoc Committee in late spring, the topic of conversation got around to a crucial problem -- food supplies. At the second meeting the group developed a plan of action for obtaining food. The guest speaker that day was in charge of commodity foods in the Boston area. The group found a warehouse and started setting up a program; however, something got bogged down, and the project is still in abeyance.

Changes in service delivery

Nothing dramatic has changed in terms of the scope and/or the nature of services offered. However, there are reasonable expectations for some progress in the latter case.

Considerable effort has been spent on Boston City Hospital to have that institution's Obstetrics-Gynecology Clinic make its services available from 7:00-9:00 P.M. on week nights and on Saturday mornings. Currently, the clinic is open only during workday hours. There are indications that some form of hour extension may come about.

Requests have also been made that BCH have the same doctor see the same prenatal patient throughout her term. Given that such an arrangement is virtually impossible for a clinic to maintain, the real hope is that (a) the doctor who makes the initial contact will be available for emergencies, (b) expectant mothers will be told reasons for the necessary rotation of attending physicians, and (c) prenatal classes for men as well as for women will be organized by the hospital.

Similar requests have been made of both the Children's Hospital Medical Center and the RCCHC. Since the above have not yet come to pass, they may not properly be part of this report. However, they illustrate a facet of AC tactics -- asking for more than is expected in hopes of obtaining something real in the long run. Also, the focus on receptivity of institutions to hear problems and explain why service occurs in the way it does is an example of a seemingly minor objective which, if reached even partially, can have a great deal to do with families' willingness to seek assistance.

RELATIONSHIP OF AC WITH PCC

As in other such programs, the Boston PCC and AC have had their internal problems. Questions concerning the status of the new Component vis-a-vis the existing parent program had to be settled. Both parents and staff had to be educated to just what the AC's responsibilities were and what the Component's relationships to the PCC and the community were to be. The PCC and AC staffs share a weekly meeting in which common issues are discussed and all agree that this goes well.

PROGRAM OBJECTIVES

° Staff training

° Contact, assess, and "recruit" families

° Linkages to resources

The Family Advocacy Component has been working toward three overall goals since the beginning of program operation. Each goal subsumes several more specific objectives. The goals will be listed in turn below, along with a discussion of activities and outcomes related to the overall goal and to the specific objectives.

Staff training

The AC's quarterly work plan states the training goal as follows: "to identify and train staff in interviewing skills, listening skills, observational skills, recording skills, knowledge of available resources, how adults learn, child-rearing practices, etc."

Instruction in listening, observing, probing and, interviewing has been obtained for outreach workers and Team Leaders through the training sessions given by Boston University's Center for Applied Social Science. These classes, led by professional research personnel with competence in social work areas, have covered all aspects of face-to-face probing, using standard techniques of presentation and role playing.

Interviewing and record-keeping skills have been taught by RCCHC. The BU program was primarily pre-service in nature, although there has been one formal follow-up session. RCCHC training will continue into a second session shortly.

The remainder of staff training has been concerned with building the knowledge of outreach workers in the health, education, and welfare areas. This has been accomplished in three ways: the three-times-per-week internal staff meetings, the inclusion of staff members at important agency linkage conferences, and the continued enrollment of staff in special short-term college level courses.

The internal staff meetings have perhaps provided the most consistent source of learning and growth. Topic rotation is planned in detail to cover a maximum of different issues. For example, discussion topics at the Tuesday morning health sessions have included early childhood developmental principles, the diseases of early childhood, prenatal and nutrition information, reproduction, accidents, mental health, and the right to health -- a basic philosophical standpoint from which the Advocacy effort stems, at least in part.

Commenting on this family of objectives, the Coordinator states: "The PCC program -- all poverty programs -- are based on the premise of citizen participation, the involvement of people who are of the same experience as the clients. This is good, but it has built into it certain problems, a large one being training."

"This has been going nicely ever since the first training session with Boston University last winter, but incentive and remuneration must get better. They (staff members) recognize their own growth, and the exposures they have had, and they recognize that they are pointing toward the opportunity of becoming more professional with more formal education and career ladder experiences. They realize that it is a very basic, bottom rung that they are on. I would like to see this program allow, either by paying tuition or by releasing time, that opportunity incentive."

Additional funds are not available and it is difficult to provide release time without eating into the AC's manpower requirements. The Coordinator continued: "There is another problem. When educational opportunities do come up, the sponsoring agencies don't always tell us about it. We had one send us a notice on September 18 that people could enroll on September 11 for classes beginning September 18 -- the same day. Our Education Advocate is trying to get late registrations now."

Part of ongoing in-service training has been to have Team Leaders or even the Coordinator accompany outreach workers on home visits. This process continues, although less intensively than it occurred at the program's inception.

Contact, assess, and "recruit" families

The work plan defines this goal as being: 'to become personally acquainted and actively involved with the residents of the catchment area, but to concentrate on identifying the needs of pregnant females and their families, and setting up a referral system which provides a range of choices while our supportive involvement enhances their personal growth.'

A considerable amount of attention has been devoted to finding and contacting pregnant women or teenagers. Once they have been located the AC keeps after them with frequent newsletter mailings and telephone calls. An attempt is made to reach every one at least once a week. The women are invited to the regular Thursday afternoon prenatal information class and, as noted earlier, it seems as if that program may have established itself. A Tuesday evening session is being planned now -- a session designed for the whole family, including husbands and children, to make participation as easy and comfortable as possible.

Actually, the monthly monitoring data on referrals submitted by the Boston AC lists only three referrals in the prenatal area. Since 41 pregnant women have been identified, this would indicate that the AC effort is almost exclusively providing information and a group format where expectant mothers may relate to each other for emotional support.

Linkages to resources

The work plan states this goal to be: "to develop a working relationship with agencies and policy makers whose work affects the target population, while assuming the role of middlemen as communicators, interpreters, and change agents."

Virtually all of the fundamental material pertaining to this goal has been presented earlier in regard to referral activities and the formation of resource committees. It should suffice here to review briefly the major points. A Professional Advisory Board composed of top level resource officials has been convened twice and contacts are being continued. Contacts with Board members themselves are being fostered actively.

Bi-weekly Ad Hoc Committees of middle-level local resource personnel have been meeting since the spring. No direct action programs have resulted from this group as yet, but the amount of information dissemination is felt to be valuable.

A number of commitments in writing have been obtained from key resources. Pressure, particularly against medical facilities, but also against other resource organizations is continuing to increase the time of availability or scope of services offered. Few, if any, measurable changes have occurred thus far, but Advocacy's efforts in the community are continuing.

Summary of objectives

Thus, the broad objectives established a while ago are still in place -- perhaps largely because they are so broad. However, there has been some subsurface movement in terms of trying to do specific things that were not originally envisioned. The process has been to start from general direction-pointing premises, to check the benefits that may reasonably be expected from various resources, and to move in the specific directions of what can be done.

THE STAFF

Boston has established a pattern of units, to which reference has been made throughout this chapter.

The three units are organized around the topics of health, education, and welfare. Each unit consists of a professional Team Leader and two paraprofessional outreach workers. Together with the Coordinator and two secretaries, they perform child advocacy in Boston.

The Coordinator describes the concept as follows: "The outreach workers on the teams are *generalists*. They are learning from *each* of those *specialists*, the Team Leaders. The outreach workers are contact people who have to learn about each of the specialties. Each has geographic areas and specific families for whom they are responsible, to maintain continuity. The exception would be that any expectant mother is automatically referred to the Health Team Leader, although that family stays with the outreach worker who made the initial contact. That has been our whole system since the beginning."

Four staff members are currently taking college courses. The Health Team Leader has just enrolled in a masters program in health education, one outreach worker is going full-time toward her B.A. and may have to give up her position at the Component, while two more are taking child development courses.

There has been some turnover among the outreach staff since the AC began operation. Three have left: one was told by her doctor that she should not work, another took a better paying social service job, and the third was released for violating the policies of the center."

Staff operations have not always been trouble-free, but there seems to be no current problem of major proportions. "They work together well. We have a great deal of diversity philosophically, by design."

The staff training involves four whole-group meetings per week. An hour is spent on Tuesday, Wednesday, and Thursday morning wherein Team Leaders mention items of interest in the news (legislation, housing conditions, medical findings, etc.), community bulletins, and any up-to-the-moment AC announcements. Cases are discussed, or catchment area conditions are mulled over.

The fourth weekly meeting is held on Friday and brings the AC and PCC staffs together.

Additionally, each Team Leader meets with her own two outreach workers for half an hour at the end of each day to go over the day's work, to make sure that accurate records are being kept, and to plan courses of action regarding specific cases encountered.

The Monday open house and the bi-weekly Ad Hoc Committees' meetings also serve as training grounds for outreach workers. The outreach staff are also involved in certain meetings with community resources from time to time to further their knowledge of resources and referral procedures.

CASE STUDY SEPTEMBER, 1972

ADVOCACY COMPONENT
OF THE
CLEVELAND PARENT-CHILD CENTER

Principal Author: Dorie Greenspan

CLEVELAND, OHIO

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CLEVELAND

FAMILY CONTACT SUMMARY [1]

Number of different families telephoned for reason other than to schedule a home visit	110 [2]
Total telephone calls to families, May through September	171
Number of different families visited in the home	282 [2]
Total home visits to families, May through September	414
Number of needs assessments completed prior to May	209
Number of needs assessments completed since May	118
Total number of families dropping from "participation"	35

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[1] For period of May through September, 1972, inclusive.

[2] Total of monthly figures of different families contacted.

CLEVELAND

REPORT OF REFERRALS [1]

MEDICAL REFERRALS

	Numbers
ALL MEDICAL (sub total)	87
PERCENT OF TOTAL REFERRALS	(34)
Prenatal care	1
Neonatal care	1
Nutrition	1
Immunization	10
Check-up	48
Medical coverage enrollment	14
Hospitalization	1
Surgery	
First aid	
Medical appliance	
Family planning	1
Eye examination	2
Hearing problem	
Speech problem	1
Dental examination	1
Dental problem	1
Medical miscellaneous	7

PSYCHOLOGICAL REFERRALS

ALL PSYCHOLOGICAL (sub total)	2
PERCENT OF TOTAL REFERRALS	(1)
Psychological testing	
Retardation	2
Psychiatric care	
Developmental/behavioral problem	
Psychological miscellaneous	

EDUCATIONAL REFERRALS

ALL EDUCATIONAL (sub total)	3
PERCENT OF TOTAL REFERRALS	(1)
Adult basic education	
Private/special school enrollment	
Facilitating transportation	
College or equivalent enrollment	
Head Start enrollment	2
Educational miscellaneous	1

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[1] Totals reported for May through September, inclusive.

CLEVELAND

EMPLOYMENT-RELATED REFERRALS

	Numbers
ALL EMPLOYMENT (sub total)	22
PERCENT OF TOTAL REFERRALS	(9)
Job rehabilitation	
Job training	16
Job placement	6
Employment miscellaneous	

HOUSING REFERRALS

	Numbers
ALL HOUSING (sub total)	60
PERCENT OF TOTAL REFERRALS	(23)
Home repair/improvements	13
Furniture/appliances	5
Relocation (ruined quarters)	16
Relocation (more space)	18
Rent payment	
Eviction	
Housing loan	
Pest control	1
Housing miscellaneous	7

WELFARE REFERRALS

	Numbers
ALL WELFARE (sub total)	30
PERCENT OF TOTAL REFERRALS	(12)
Food stamps	9
Special welfare services	1
Increased welfare payment	10
Welfare enrollment	8
Veterans Admin./Social Security	
Welfare miscellaneous	2

MISCELLANEOUS REFERRALS

	Numbers
ALL MISCELLANEOUS (sub total)	53
PERCENT OF TOTAL REFERRALS	(20)
Help obtain clothing	9
PCC referral for enrollment	7
Legal problem	2
General transportation	7
Day care	3
Baby sitting	3
Help obtain emergency food	5
General information/miscellaneous	17

	Numbers
TOTAL NUMBER OF RESOURCE CONTACTS	257 (100)

THE COMMUNITY

The catchment area

In Hough itself, there is considerably new housing as a result of neighborhood-based Citizen Corporations and efforts in the private sector. However, the catchment area, which is only a small portion of Hough, has no low-income government housing. The majority of AC families are on welfare and for these welfare families the housing conditions are grossly inadequate.

In the catchment area, there seem to be more abandoned, vandalized, burnt-out homes than there are intact residences. Each of these decaying sites is a hazard to children and a haven for junkies and criminals. Houses that are intact are in poor condition, apparently themselves on the verge of abandonment.

The Hough Parent-Child Center (PCC) and Advocacy Component are oases in this impoverished catchment area. The PCC and its Advocacy Component maintain separate offices which are newly renovated, clean, and well equipped. The Component's office is a five-room apartment that was converted into a small but efficient working space.

The target population

The Hough population is black and poor. The Advocacy Coordinator estimates that approximately 85% of the Advocacy population receives some type of public assistance.

They are a difficult population to reach, as they are afraid to reveal themselves, afraid of the "agency image." Information given to Outreach Workers during the initial needs assessment was often false or incomplete. People's trust had to be built and nurtured before accurate reports of even minor problems would emerge. In common with other programs, in other communities, people who have been "social worked" are apt to be skeptical when they are being offered a new form of help: too often they have been disappointed.

THE NEEDS ASSESSMENT

Three hundred and twenty-seven families have been assessed to date; some of these families were identified through lists given to the AC by community agencies. At the time of these assessments, the Component's staff structure differed from its current structure. Although a "staff organization" section appears later in this report, it will be discussed now in terms of its relationship to the needs assessment.

Originally, the Cleveland Advocacy Component employed twelve (12) Assistants and four (4) Outreach Specialists. Each Assistant worked six hours a week conducting only needs assessments. They maintained no contact with connecting agencies and made no referrals. Their task was solely to relay information obtained during needs assessments to Specialists who were, in turn, responsible for effecting appropriate referrals.

Upon completion of the 327 needs assessments, the Coordinator learned that Specialists were saying that they had an insufficient workload and that they were not receiving "good" information from the Assistants.

At the same time, the program lost six (6) Assistants. One became pregnant, one decided that she preferred being a member of the PAC, and four (4) quit because of the time commitment. As a result of these resignations, of the Specialist's complaints, and of a thorough review of AC family folders, the remaining Assistants were terminated with the understanding that they could be called upon to participate in special, one-day projects.

Looking back on this situation, the Coordinator cites poor communication flow and insufficient training of Assistants as major problems. He asserts that while proper training of indigenous staff takes a great deal of time, Assistants worked six (6) hours per week and did not have enough time to fully develop their skills. In addition, communication became a problem because indigenous Specialists were supervising indigenous Assistants. Specialists were unaccustomed to supervisory roles, and Assistants were not amenable to receiving instructions from persons they considered peers. The right questions were not being asked, and the needed information, if in fact it was available, was not being transmitted.

In an effort to rectify this situation and to improve upon the work already done, the Coordinator has been personally reviewing each family's case file. A memorandum is written for every case, suggesting appropriate courses of action.

Specialists should find new needs assessments easier, given the new system of organization. In addition to requiring that Specialists undertake both needs assessments and referrals, the new structure also provides each Specialist with a specific geographical area of responsibility. Thus, each Specialist and her client will have a better opportunity to learn more about one another, and to build a firm working relationship. This should result in fewer refusals to participate in the needs assessment, and should also make the worker more knowledgeable about the movement of families in and out of the community.

The 327 needs assessments completed to date include approximately 400 of the catchment area's 2,000 dwelling units. The aim is to continue the needs assessment effort until all families with children ages 0-5 in the area have been identified.

At present, workers are not actively pursuing new needs assessments. In contrast with the initial phase, the primary concern now is to get service to the people who have already been assessed, so the program can assure its credibility.

Information gathered

Although the needs assessment generated a number of internal staff problems, it also provided original information on community needs.

Assistants found "some" cases of mental retardation. Although the Coordinator has said that the Assistants could not "properly" identify mental retardation, and that he would like to hire a Specialist with a master's degree in psychology to do so, this experience did lead to the identification of a current service gap: there is no one agency in the community to advocate for mentally retarded children under the ages of six. Children are now being referred to the Hough-Norwood Health Center for testing. In addition, contact has been made with the Mental Development Center of Case

Western University. Case Western has recently hired a staff member whose job it is to make the Center's services relevant to the black community. The Coordinator will try to build upon this development so care can be given to target children, and so AC staff can receive appropriate training.

The needs assessment underscored the need for relating people to existing health services, the lack of understanding people had regarding welfare, and again, the deplorable housing conditions characteristic of the community.

Use of data

Data obtained from the survey have helped to order AC priorities. Pre-natal care, once thought to be a necessary thrust of the program, may be given lower priority as a result of having failed to find as many pregnant women in need of this care as had been expected. This finding will be discussed in further detail under "objectives."

Local agencies have used the needs assessment data as a tool against which to test their respective program's outreach efforts. Hough-Norwood Health Center has compared their enrollment lists to the numbers of people assessed who said they were registered for coverage in the facility. The Maternity and Infant Care Project used the needs assessment to ascertain whether or not they were reaching all persons in the catchment area. The Hough Parent-Child Center used the list of identified families to recruit those persons eligible for PCC program.

RELATIONSHIPS WITH FAMILIES

Since the inception of the Cleveland Advocacy Component, staff members have completed needs assessments for 327 families. The Coordinator estimates that approximately 100 to 150 of these families have been worked with by his staff. These are considered ongoing families, i.e., families for whom a referral has been made. It is hoped that the staff will, at some time, work with all families identified through the survey.

As noted earlier, the Component initially had a structure that entailed one person being responsible for needs assessment, and another for referral. Since the reorganization, considerably more time has been spent on referrals; a consequence of this being that workers have time to see only those families for whom they are making referrals. This means that contact with families for whom a specific problem is not under attention is limited. Workers do, sometimes, see these families, but it is most often a result of the worker being in the area and meeting the family by accident, on the street. There is, at this time, no mechanism for maintence of contact.

Those families with appointments at the Hough-Norwood Health Center receive a telephone call the night before to remind them of their appointment time. This task is done by the Component's Mainstream employee, who is being trained in outreach by the program.

Referrals

As of the end of August, 216 referrals had been made to community agencies. Some Advocates have found that it is difficult to motivate families to keep appointments made for them by the AC, and feel that this frustration is a function of the nature of the families they serve. However, in this program, the Coordinator does not see this as a problem area; he estimates that only 10-15% of all referrals made by his workers are not carried our by families.

The majority of referrals made by the program staff are to the Hough-Norwood Health Center; these referrals are usually carried out by the families. In addition to the advance reminder noted above, families are provided with a bus schedule so they can plan transportation. The 10-15% of incomplete referrals are often appointments not kept with such offices as the Housing Authority, Real Estate offices, and the Bureau of Vital Statistics.

Follow-up

Cleveland Specialists always try to follow-up on all referrals, contacting both the resource and the individual. A referral form has been devised by the Coordinator on which a worker lists the nature of the problem, the referral source, the outcome, and the follow-up. These forms provide an ongoing account of a family's case history, as well as a data pool from which monthly monitoring information is drawn.

During follow-up visits, workers often are told about families' perceptions of treatment and services received at a particular resource. These impressions are discussed with agency staff during meetings with the Advocacy Coordinator.

High-risk and/or multi-problem families

The Coordinator and his staff define high-risk in terms of criteria specified for completion of the Supplemental Monthly Monitoring Form. That is, high-risk person is identified as a pregnant woman who is either under 18 years of age or over 40. However, the Coordinator adds that, "We live in a high-risk area. Ninety-eight percent of our families are multi-problem families."

As an illustration of such a family, the Coordinator described a mother with five children, two of whom are below the age of five. The children do not have birth certificates and the mother is unaware of the process by which they are obtained. (In Cleveland, birth certificates are not issued at the time of a child's birth, but must be applied for at the Bureau of Vital Statistics.) In addition, none of the children has completed the immunization sequence. There is no male figure to serve as a model for the children, and the mother has "noted emotional problems." Specialists are now working with the family to see that birth certificates are obtained and that the children are enrolled in an immunization program.

FAMILY GROUP PARTICIPATION

Mass meetings

The Cleveland Component has not held any mass meetings relating to specific issues. The Coordinator says that they cannot hold such meetings because, "We're still gathering facts on what's going on," i.e., until the needs assessments have been completed.

Committees

Committees of Advocacy families have not been formed by this program. The idea has not been considered because, "there are multitudes of committees already in the area."

The committees referred to here are those working with local and county organizations.

Ongoing groups

No ongoing groups, e.g., sessions for teenagers, pregnant women, have been formed because the Coordinator feels that the primary thrust of this program should be on outreach, information, and referral. Rather than to create a new service, the Coordinator feels that it is important to refer persons to existing services.

RELATIONSHIPS WITH COMMUNITY RESOURCES

The Cleveland Advocacy Component is still in the process of identifying resource agencies in the community and informing themselves of the responsibilities and services provided by each. This process has been slow because only the Coordinator and occasionally the Staff Development Coordinator have been involved in agency identification. The Specialist staff has not participated in the identification procedures because it was felt that they needed more instruction and supervision before tackling this task.

The Child Advocate's exclusive domain has included contacting, informing, and mobilizing community resources, in addition to identifying agencies. All meetings with administrators of other agencies have been attended by the Coordinator.

He has met with twenty-six agency heads. In addition, he has become a member of the Steering Committee of the Cuyahoga County Health Consumers Coalition, and is attempting to have himself appointed ot the County Board of Mental Retardation. Membership in such groups could give him the opportunity to deal with problems from a position of increased knowledge and power.

Contractual agreements

The Cleveland Advocacy Component has not made any contracts for services with other agencies. It is, however, considering an arrangement with the Hough-Norwood Health Center.

At one time, the AC Coordinator was considering linking up with Hough-Norwood's night telephone emergency line. This was explored; it developed that the Hough-Norwood night line provides persons with emergency information, directing any caller to appropriate facilities. As another option, the Coordinator is considering the possibility of putting a tape recording on the AC's telephone line directing callers to call the Hough-Norwood night line number.

Definite arrangements have not, as yet, been made.

Referrals from other agencies

The AC staff refers families to twenty-six community agencies; occasionally, these agencies use the Advocacy program as a resource, to date, seven agencies have used the AC as a referral source. Examples of developing relationships include the following:

The Legal Aide Society has referred two of its clients to the Advocacy Component. Both persons were in need of food and clothing, that the Society could not provide. Workers were able to refer these clients to facilities which had the goods available.

The Hough Parent-Child Center is perhaps the largest source of referrals to the AC. It has referred approximately twenty-five families who were ineligible for PCC program to the Advocacy Component. Were necessary or appropriate, the AC specialists conducted needs assessments on the families and dealt with the indicated problems.

A local elementary school counselor plans to refer to the AC,families with whom she is having difficulty reaching. Although this has not yet been done, the verbal commitment is an indication of program status as seen by other community agencies.

Ongoing meetings with other agencies

Since relevant agencies are still being identified by the AC Coordinator, arrangements for ongoing policy-making meetings with community agencies have not been made. However, the Coordinator has met with each of several agencies on several occasions. Among these agencies are Hough-Norwood, Mt. Sinai Hospital, the Maternal and Infant Child Care Project, and Better Homes of Cleveland. Such meetings, though not ongoing, do provide a basis for cooperative working relationships.

As a result of meetings with the Director of the Department of Child Hygiene, the City Health Department now provides the AC with lists of all babies born in three neighboring hospitals. The staff is able to use these lists as a check tool, to see that they are actually reaching all pregnant women. More important, the AC workers can contact these mothers to make certain that they enroll in a Well-Baby program.

Agency coordination

The Cleveland Advocacy Component has facilitated and coordinated the work of a number of community agencies. For example, the Environmental Health Services Department (EHS) has received a grant to conduct a lead poison testing program in the area. The program calls for inspection of the walls of community residences and the subsequent patching of places in which lead content is dangerously high. The Coordinator was able to introduce EHS to the local chapter of the Concentrated Employment Program (CEP). Plans are now being made to train CEP men to work with EHS employees to do the necessary maintenance on apartments with lead poisoning violations. This work would then be part of the CEP job training program.

The City Health Department referred Project Find and Aid to the Elderly to the Advocacy Component. Both agencies were interested in being put in touch with groups concerned with the needs of the aged. The Coordinator connected these agencies with Better Homes of Cleveland.

Changes in service delivery

As a result of Advocacy efforts, some agencies have changed their procedures or made their services more available. For example, the Hough-Norwood Health Center provides the Advocacy Component with a list of persons in the AC's catchment area who have clinic appointments for the following day. This came about following discussion with staff from the Health Action Services Department of the Clinic.

Although this is viewed by the Coordinator as a change in clinic procedure, it appears to be less of a procedural change than a mutually beneficial agreement. Although clinic practice is unchanged, the AC receives the list daily, and the Mainstream worker on staff telephones or visits all persons with appointments to try to promote attendance. This is an important step toward making the service more available to the community.

As a result of a near tragedy, followed by the intercession of the Coordinator, Mt. Sinai Hospital has made an actual change in the services they deliver. An Advocacy mother took her small, sick child to Mt. Sinai Hospital one night. The child's illness was diagnosed as a cold, and the mother was told to take the child home. During the night, the child's illness continued to disturb the mother and so she brought the child to Mt. Sinai once more. Again she was told it was a cold and to return home. Unconvinced, the mother took the child to St. Alexis Hospital. By this time, it was already quite early in the morning. At St. Alexis, the mother was informed that the child was suffering from a serious case of bronchial pneumonia and that hospitalization was necessary.

The Coordinator brought the situation to the attention of the Director of Urban Affairs at Mt. Sinai. (The Director was well known to the Component, as he had participated in AC staff training sessions.) The Director explained that bronchial pneumonia, in its early stages, is difficult to detect, and often shows the same symptoms as a common cold. However, in an effort to prevent future occurrences, Mt. Sinai now takes a throat culture whenever there is the possibility of a respiratory ailment. It was later discovered that the taking of a throat culture was always part of the normal routine examination at Mt. Sinai, but that it had somehow becomes a practice that had fallen into disuse.

Far less dramatic, but important nonetheless, is the situation with the local Head Start program. The elementary school was concerned about the status of Head Start enrollments. The local Head Start program gave admission preference to older children and said they could only take five year-olds into their program because there were so many five year-olds that it was impossible to accept younger children. Meanwhile, both the AC staff and the elementary school personnel knew of children whose parents wanted them enrolled. The AC staff Development Coordinator began an investigation of the situation and found that there were, in fact, forty vacancies in the program. When she brought this to the attention of Head Start, the program asked the Advocacy Component to locate children who would be eligible for Head Start. The

AC Specialists were able to make referrals for the vacancies.

RELATIONSHIP OF AC TO PCC

Perhaps the best way to characterize the relationship of the AC to the PCC is to quote from a recent monthly report written by the Child Advocate Coordinator.

When asked, "what input do the PCC staff, parents and Policy Council, have in the Advocacy Component," the Coordinator wrote:

> "I find it very difficult to relate to this question. We are the Hough Parent and Child Center staff, we all work together to assist in the deliverance of service to people in the community."

And indeed, this is the feeling one gets, not only from the Coordinator, but from the Acting Director of the PCC and his staff.

In addition to exchanging all reports issued by the PCC and its Component, both the PCC and the AC staff share in joint meetings. Every Monday, there is an Administrative Staff Meeting attended by Center and Advocacy staff. Directly after this meeting, there is a program meeting attended by the Social Services Component of the PCC, the Nurse and Assistant Director, and by the Advocacy staff. Outcomes of referrals made by Advocacy staff to Center staff, problems that Center staff have identified which require referral to Advocacy, and new resources which have been identified, are discussed during this meeting. The PCC and its AC also share in-service training.

Although neither the Center staff nor the Component staff work directly with each other's families, each does use the other as a resource. In addition, the PCC uses its Component as its initial agent in the recruitment of new program participants.

The Policy Advisory Council (PAC) has an Advocacy Committee which, although not active during the summer, will again be functional in the fall. The PAC Chairman receives the montly reports written by the Advocacy Coordinator and is kept informed of new developments.

PROGRAM OBJECTIVES

The following are the short-range objectives of the Advocacy Component:

- Assessing health, nutrition, educational, and social service resources. Taking steps toward improving services.

- Pre-natal care: see that more mothers receive better care, earlier, in their pregnancies.

- Focal children's medical care: get more children to the clinic on a regular basis.

- Health education for parents.

- Family planning.

- Connecting families with needed services: make families and Component aware of needs, make referrals or appointments, and follow-through.

- Make environment safe and healthy.

- Recruit and train volunteers.

Each objective will be discussed separately below.

- Assessing health, nutrition, educational and social service resources. Taking steps toward improvement of services.

As was mentioned earlier in this report, the Cleveland Advocacy Component staff is still in the process of interviewing for needs assessments; of making referrals on problems indicated in completed assessments, and of identifying the existing resources in the community.

The Coordinator has said that the identification of resources is "more time-consuming than was originally thought." He has established working relationships with twenty-six (26) community agencies, but Cleveland is served by many other organizations. In his quarterly work plan for September 1972, he states that he would like to meet with an additional fifteen (15) administrators of agencies which are not, as yet, working closely with the Component.

According to the Coordinator, the process of identification, which includes contacting the agency as well as just learning of its existence, has been hampered by the level of staff competence. As noted previously, the Coordinator feels that his staff needs extensive instruction and supervision, thus, the organization is structured in such a way as to allow only the Coordinator to contact agencies.

The task has been facilitated by his previous experience as the Director of a residential center for boys in the Hough area. Thus, when he assumed the position of Coordinator, he already knew some of the key agency persons, and was aware of some of the resources available.

With identification still a major task, a concentrated effort to improve services has not been made. However, when a problem or gap in services presents itself, the staff tries to rectify the situation as soon as possible. Such was the case with Mt. Sinai Hospital, and with the Head Start program. A serious service problem was identified and steps were immediately taken to make the needed improvements.

- Pre-natal care: see that more mothers receive better care, earlier, in their pregnancies.

The original thought behind this objective was to make certain that all pregnant women were enrolled in a pre-natal program. There has since been a shift in emphasis as a result of information gathered through the needs assessments.

The initial needs assessment identified fifty-one (51) pregnant women. Within this group, forty-seven (47) were receiving pre-natal care. In addition, the Component received a list from the Bureau of Child Hygiene showing that, during one week, seven (7) babies had been born. Of the seven mothers, five (5) had completed needs assessments, and all five were enrolled in a pre-natal program.

As a result of the above information, several questions are now being asked by the Coordinator:

- Are all pregnant women in the catchment area being identified by the AC?
- Do women who receive pre-natal care also receive post-natal treatment?
- If pre-natal care is being obtained, how early is this care provided?

Identification of pregnant women is done through a door-to-door survey and needs assessments. The Coordinator, uncertain as to whether all preganant women are being reached, plans to contact the Board of Education and other community agencies to become acquainted with the methods by which these groups identify pregnant women.

The lists of deliveries in three hospitals, made available by the Bureau of Child Hygiene, will, if continued, serve two purposes. It will be used as reference so the AC staff can check its efforts and measure its effectiveness in identifying pregnant women. The list will also serve as a referral base. That is, the staff will undertake a needs assessment for each mother on the list who has not been previously contacted by the AC. In addition, and more important, Specialists will be able to visit these new mothers and encourage and help them to receive post-natal attention.

Lastly, if most women receive pre-natal care, the Specialists can then concentrate their efforts on seeing that women receive this attention early in their pregnancies, preferably during the first trimester. At this time, it it not known just when women begin seeing doctors during pregnancy. Early pre-natal care is of especial importance. The 1971 census data for the catchment are shows:

- 190 births
- 30 premature births
- 11 babies dead at birth

- Focal children's medical care: get more children to the clinic on a regular basis.

This is an objective that is being worked on steadily by the staff and is moving rapidly toward achievement.

Hough-Norwood Health Center is the facility being used for all referrals in this area. City Health Clinics are located in the area; however, the Coordinator reports that these clinics are working under most adverse conditions. Four of the city's seven Health Clinics have been closed. Money allocated for City Clinics has dropped from $136,000 in 1969 to $73,000 in 1972, a period marked by increased costs.

All home visits by nurses have been stopped, and the nursing staff has been cut from 86 nurses in 1970 to 26 in 1972. In addition, five administrative positions have been vacated, and four more are due to be vacated in the near future, due to a severe lack of funds. The crisis being faced by City Health Clinics is common to many other public agencies in the county.

The AC staff has been able to register most of their target families for coverage at Hough-Norwood. Enrollment entails the client (1) having all the necessary paper work completed, (2) receiving all lab work, and (3) having a complete physical. The enrollment precess is long, but it is not difficult and clients have few complaints. Hough-Norwood handles 6,000 clients per month and provides immunizations and dental care, as well as the necessary comprehensive health services.

As mentioned previously, the AC and Hough-Norwood have made an agreement whereby Hough supplies the AC's Mainstream worker with a list of all persons in the catchment area with appointments for the following day. The worker notifies each person the night before, to assure better, more regular service.

The Advocacy Coordinator is now making plans with the Public Health and Welfare agencies in Cleveland to hold a one-day immunization clinic. Such a program would not only provide immunizations, but would emphasize the need for proper health care for the children. As an inducement to participation, the Coordinator is looking into the possibility of giving mothers Green Stamps for each child brought to the clinic.

The project is proposed for late October or early November. The immunization clinic would be a special event that would employ Assistants. Those Assistants who were earlier "put on call," would be used to alert families to the upcoming project.

- Health education for parents

Very little has been done in this area, other than the provision of supplementary information. Workers are trying, when appropriate, to stress the importance of preventive medicine to their families, but, as the Coordinator pointed out, "We are still in the process of broadening Specialists' knowledge of preventive medicine."

- Family planning

Family planning does not seem to be a major thrust of this Component. Workers make family planning referrals when indicated, but it is reported that six family planning agencies in the area are doing an effective job of picking up on clients.

- Connecting families with needed services: make families and Component aware of needs, make referrals or appointments, and follow-through.

This, of course, is the foundation of the Advocacy Component and the day-to-day meat of the organization. If the Advocacy Component is seen as an information and referral service, this would have to be the main objective.

Work being done in this area -- needs assessments, identification of resources, the building of cooperative relationships with agencies, the actual referring of clients to resources, and the process of follow-up -- have been detailed elsewhere in this report. What is interesting to note here, is the work being done to supplement existing services.

The Coordinator feels it is important to encourage people within the community to offer services to each other where possible. This may involve using a neighbor for a babysitter when an appointment must be kept, or it may involve provision of actual material. To this end, families in the area have been asked to donate clothing, if possible. An agreement has been made with Better Homes of Cleveland for them to supply storage space for the goods contributed. It is hoped that donations of furniture and equipment will be received as well, and these, too, will be stored by Better Homes.

Through the door-to-door needs assessment, a seamstress was found who was willing to donate her time and talent. The person wanting the clothing will have to supply the fabric, but the labor will be free. The Coordinator hopes to be able to find and utilize additional "community resources."

- Making the environment safe and healthy

This is an area of tremendous concern for the Cleveland Advocacy Component, and one in which frustration seems to be lurking behind every idea.

The City Health Department and the Environmental Health Services (EHS) are key agencies in the areas of housing, and rat and rodent control. The Coordinator met with representatives from both agencies in order to better understand just what the agencies' responsibilities are, and what is preventing them from action. The answer, of course, is money. Both agencies are short on funds and staff.

The process of locating landlords of vacant, abandoned, and vandalized buildings is one that requires time, expense, and research. To find the landlord entails an expensive title search. If he is found, he is then served a summons. The landlord is then called to court and told he will be given the opportunity to rehabilitate the property before the City moves to take possession of the land. The next step is usually a long delay before the landlord decides that, because of the unprofitableness of the situation, he will do nothing. The City then takes over the building.

Once this is done, the building is razed. This, again, is an uprofitable situation. The City loses tax revenue from the land, must pay the costs of razing the building, and then cannot find a buyer for the property. With such resultant problems, it becomes clear why the City is not anxious to start the above proceedings.

The Coordinator has suggested to the City Health Department and to EHS, that, to cut costs, the Army Corps of Engineers be employed to raze the buildings. This would contribute only a very partial solution. The time factor and the use of the land once the building is razed, are still formidable problems.

The bright note amidst all these problems is the aforementioned Lead Poisoning Program. Under federal funds, the Environmental Health Service provides a lead poisoning inspection of all homes and the subsequent maintenance necessary to remove identified violations.

The Advocacy Component is working closely with EHS in this program. The Coordinator was instrumental in introducing EHS to the Concentrated Employment Program (CEP). The result of this link-up was the opening of discussion, which could lead to an agreement to have CEP persons trained to repair the lead poisoning violations in community homes in conjunction with EHS personnel. In addition, the Advocacy Component is assuming responsibility for assembling all agencies with Outreach Workers so personnel from EHS will be able to hold a training session on the Lead Poisoning Program. Full cooperation is expected.

- Recruit and train volunteers

This is a short-range objective that must wait a longer time for implementation. When the objective was originally cast, the Advocacy Coordinator was not fully aware of the time and effort needed to train staff, even full-time regular staff. After the Component's experience with the part-time Assistants, and the problems with communication flow, it was decided to expend a great deal of energy on training and supervising regular staff, rather than working with volunteers. This does not mean that the objective will be eliminated, but it does mean that the AC will "put its own house in order" before moving on to volunteers.

At present, the Component has a VISTA volunteer and an Operation Mainstream person on staff. Both employees, though not permanent staff, will be with the program for approximately one year, and therefore cannot be classed in the same category as volunteers. Their finctions will be described in the staff section.

STAFF

Background and organization

The Coordinator, who holds an M.S. in Urban Studies, is not originally, or now for that matter, a community resident. He is, however, very familiar with the special problems of the ghetto, and spent three years prior to taking this position as Coordinator, as Director of a residential center inside Hough.

The Staff Development Coordinator spent seven years doing outreach work with the Maternity and Infant Care Project. In her position at the AC, she is not only responsible for aiding in supervision of the Specialist staff, she acts as liaison between the Coordinator and the Specialists.

The four Advocacy Specialists are all community residents. The PCC Policy Advisory Council wrote into the AC proposal that, in hiring Specialists, PCC parents were to be given both the first opportunity to interview for the positions, and preference. The Component followed this mandate and has "hired from within."

One of the Specialists is enrolled in night school and has completed 50 hours of work toward a degree in early childhood. The educational status of the remaining Specialists has become an area of dispute. The salary scale in this Component is structured so that a worker with a high school diploma receives a higher salary than one without. Formal investigations of Specialists' educational backgrounds were not made at the time of hiring. Since then, discrepancies have been found between what was said to be true and what seems, actually, to be true. This is a situation that the Coordinator intends to clear up in the very near future.

The VISTA volunteer works closely with the Staff Development Coordinator setting up schedules for training sessions. At the start of the project, she, herself, conducted a course on techniques of report writing and the basics of English.

The Operation Mainstream employee is on staff as a trainee. He is responsible for notifying parents of their appointments at Hough-Norwood. Notification is done by telephone or home visit, and provides him with experience in working with AC families.

With the exception of the Mainstream Worker, the Coordinator is the only male at the Component. In addition, he is a professional, and these two factors were the cause of some problems during program's start-up phase. An incident with a particular Specialist, one no longer on staff, caused some dismay. The Specialist's hostility and acting-out behavior resulted in a series of miscommunications and unfollowed instructions. Added to this, was the Coordinator's difficulty in being able to communicate his ideas and plans to his staff on a level they would understand.

The Staff Development Coordinator proved to be most helpful in alleviating these situations. Following her suggestion, the Coordinator keeps staff relations on a formal, rather than first name, basis. This has proved a successful technique in that, by having everyone called Miss ___, the boundaries of a relationship are drawn.

Communication between the professional Coordinator and his non-professional staff has constituted something of a problem. As a result, the Staff Development Coordinator serves as liaison between the Coordinator and the workers during full staff meetings. He will discuss a point and then she will often "translate" it into a language better assimilated by the non-professional staff.

Staff turnover

All told, the Advocacy Component has lost eight staff members: six Assistants, one Secretary, and one Specialist.

In terms of the Assistants, one became pregnant, one preferred being a member of the PAC, and four resigned because of time constraints.

The Secretary was let go because she did not have the proper skills, and it was felt that she would need too much time to develop these skills.

The Specialist was dismissed because, as the Coordinator noted: "There was constant confusion, she could not take direction. It came out during the sensitivity training that she looked at me the same way she looked at her husband - she couldn't take orders from either of us."

With the exception of the Assistants, all positions have been filled.

Staff training

The Cleveland Advocacy Component is continuing to place emphasis on staff training and evaluation. At the start of the program, the staff was given a course in report writing, attended lectures by community resource personnel, visited agencies, and spent two days in sensitivity training with a Dean from Michigan State University.

Lectures by outside resource persons, group discussions, field trips, and courses in report writing and information gathering continue. The Staff Development Coordinator tries to schedule a lecture every Friday, and if an outside agency person cannot attend, she or the Coordinator conducts the session.

Supervision and evaluation of staff is constant. The Staff Development Coordinator meets with each worker once a week to draw up a plan of action. This is a plan for the week's activities listing persons to be seen, appointments to be made, follow-ups to be done, and anything else that may be pending for that week. A minimum of twenty families must be listed in the plan. In order for a worker to put the plan of action into use, it must be initialed either by the Coordinator, or the Staff Development Coordinator.

The Coordinator reviews each case file and then meets individually with each worker once a week. During their meeting, he supplies the worker with instructions and suggestions as to how to handle particular cases.

He is quite sure that the ongoing supervision now given workers should eliminate recurrence of the problems experienced in the beginning of the program.

CASE STUDY SEPTEMBER, 1972

ADVOCACY COMPONENT
OF THE
HUNTINGTON PARENT-CHILD CENTER

Principal Author: Dorie Greenspan

HUNTINGTON, WEST VIRGINIA

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HUNTINGTON

FAMILY CONTACT SUMMARY [1]

Number of different families telephoned for reason other than to schedule a home visit	16 [2]
Total telephone calls to families, May through September	20
Number of different families visited in the home	139 [2]
Total home visits to families, May through September	390
Number of needs assessments completed prior to May	150
Number of needs assessments completed since May	21
Total number of families dropping from "participation"	51

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[1] For period of May through September, 1972, inclusive.

[2] Total of monthly figures of different families contacted.

HUNTINGTON

REPORT OF REFERRALS [1]

	Numbers
MEDICAL REFERRALS	
ALL MEDICAL (sub total)	86
PERCENT OF TOTAL REFERRALS	(82)
Prenatal care	1
Neonatal care	
Nutrition	27
Immunization	20
Check-up	7
Medical coverage enrollment	2
Hospitalization	1
Surgery	1
First aid	1
Medical appliance	1
Family planning	8
Eye examination	1
Hearing problem	
Speech problem	
Dental examination	3
Dental problem	12
Medical miscellaneous	1
PSYCHOLOGICAL REFERRALS	
ALL PSYCHOLOGICAL (sub total)	
PERCENT OF TOTAL REFERRALS	
Psychological testing	
Retardation	
Psychiatric care	
Developmental/behavioral problem	
Psychological miscellaneous	
EDUCATIONAL REFERRALS	
ALL EDUCATIONAL (sub total)	
PERCENT OF TOTAL REFERRALS	
Adult basic education	
Private/special school enrollment	
Facilitating transportation	
College or equivalent enrollment	
Head Start enrollment	
Educational miscellaneous	

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[1] Totals reported for May through September, inclusive.

HUNTINGTON

EMPLOYMENT-RELATED REFERRALS

	Numbers
ALL EMPLOYMENT (sub total)	1
PERCENT OF TOTAL REFERRALS	(1)
Job rehabilitation	1
Job training	
Job placement	
Employment miscellaneous	

HOUSING REFERRALS

	Numbers
ALL HOUSING (sub total)	2
PERCENT OF TOTAL REFERRALS	(2)
Home repair/improvements	1
Furniture/appliances	1
Relocation (ruined quarters)	
Relocation (more space)	
Rent payment	
Eviction	
Housing loan	
Pest control	
Housing miscellaneous	

WELFARE REFERRALS

	Numbers
ALL WELFARE (sub total)	8
PERCENT OF TOTAL REFERRALS	(8)
Food stamps	3
Special welfare services	
Increased welfare payment	1
Welfare enrollment	1
Veterans Admin./Social Security	
Welfare miscellaneous	3

MISCELLANEOUS REFERRALS

	Numbers
ALL MISCELLANEOUS (sub total)	8
PERCENT OF TOTAL REFERRALS	(8)
Help obtain clothing	4
PCC referral for enrollment	
Legal problem	
General transportation	1
Day care	
Baby sitting	
Help obtain emergency food	2
General information/miscellaneous	1

	Numbers
TOTAL NUMBER OF RESOURCE CONTACTS	105 (100)

THE COMMUNITY

The catchment area

The Huntington Parent-Child Center (PCC) and Advocacy Component (AC) each have administrative offices in a building used predominantly by the Southwestern Community Action Council (SCAC), the CAP agency. The PCC uses an office that is divided into four spaces and the Advocacy Coordinator uses an office down the hall from PCC.

Huntington, the city in which the administrative offices are located, gives no indication of what lies ahead in the catchment area. The city of Huntington with its wide main street, department stores, movie theaters and university campus looks like so many other small cities and college towns. Homes around the center of town are sturdy, brick buildings with neatly-kept lawns. Large churches can be found on almost every other block. During the day there is the normal hustle and bustle of people going to and from work and shopping in the many stores.

As I drove around Huntington with the Coordinator he pointed out the banks of the river with its high flood walls, the factory in which railroad cars are built and "the poor side of town." The "poor side," running about ten blocks, houses Huntington's black population. The area is certainly nothing at all like a poor urban community, but to Huntington's residents, this is their ghetto.

Once outside of Huntington, driving the 65 miles or so to Harts, in Lincoln County, one of the PCC/AC sites, the picture of West Virginia, "the forgotten America," begins to emerge. The landscape remains beautiful, hills covered with trees beginning to turn their fall colors, the occasional green valleys and the ever present jagged rocks with coal seams. What changes are the houses on the land. No longer are there newly-built ranch houses or freshly painted clapboard homes: now they are shacks without windows, without plumbing and without secure footing to keep them from floating away when the creek overflows. Shacks are scattered haphazardly along the roads and hills without thought as to what location would best withstand the heavy rain, snow and floods.

On the back roads and in the hollows the housing seems even worse. The situation is probably no different in the hollows from that off the main road, but it appears more dismal as the roads are dirt and the houses are precariously perched on the side of the hill.

Children of school age were standing on the porch of a back road house as we drove by. They watched the car go by expressionless, eyes blank. It was this blank look that struck one as being worse than even the most dilapidated shack.

The second site, Crum, in Wayne County perhaps 65 miles from the first, is no different, the same run-down shacks and the same blank stares.

The lack of resources is a problem common to both Harts and Crum. There are no medical facilities within a 25 mile radius of either site. Transportation to and from anywhere in the area is difficult. Roads, with the exception of State and Federal highways, are poor and often inaccessible due to snow or flood. Cars are a luxury few can afford. An emergency situation is made worse by the poor transportation and the unavailability of telephones.

The target population

West Virginia is coal mining country and if a man works it is probably in the mines. Mining may provide an income, but the miner's working life is short. Black lung disease is a major illness in this area. Black lung may be among the most serious of illnesses, but in the catchment areas where medical attention is so difficult to obtain, even a common cold may grow to be a real problem.

These "mountain people," as the PCC director refers to them, are private people, distrustful of outsiders and wary of things with which they are not totally familiar. Even Advocacy Outreach Workers, who are community people themselves, have had difficulty drawing out information from this population.

They are not an educated population and this, coupled with their distrust of things unknown, often causes them to misunderstand new ideas that are presented to them. Workers must make special efforts to detail every plan and reassure families of the idea's worth.

unemployment is rampant. Approximately 40% of the population of Lincoln and Wayne Counties are unemployed. The only jobs available to males are in the mines and these are 20-30 miles from the target sites. Even if a man were healthy and willing to work in the mines, it would be most difficult for him to manage the transportation.

THE NEEDS ASSESSMENT

The Huntington Advocacy Component staff originally completed 140 needs assessments by conducting a door-to-door survey in addition to using the snowball technique. That is, after a worker had interviewed a family, she would ask them if they knew of another family in which there were young children. Being able to go into a home and say that you had just spoken to a neighbor made an easier introduction.

Essentially, the needs assessment phase has been completed. Assessments are now done on new families referred to the AC, but there is no active, on-going needs assessment survey being done at this time except with currently enrolled families.

Problems

Poor roads and heavy snow and rain hampered the progress of workers conducting the survey.

Once workers were able to get to and inside families' homes, they often found it difficult to obtain "complete or legitimate information" on the first visit. Persons were slow to reveal their needs and so workers would return in order to get clearer pictures of the situation. This, of course, was not a problem unique to Huntington.

Use of data

All information collected from the needs assessments has been IBM tabulated and bound in two massive volumes. This information has already been used by the Region II Health Planning Association.

The needs assessment did not serve to prioritize the Component's objectives, but rather to reinforce what was already known. The PCC had worked in the catchment area and agency meetings had been held prior to the establishment of the Advocacy Component and so the need for health service facilities was already a well recognized fact.

For the Component as a program, the needs assessment may not have uncovered any startling findings, but it served as an introduction to the needs of individual families.

Data from the needs assessment have been reviewed by the State Health Department. The Department is considering starting a total immunization program and was interested in knowing the number of unimmunized children located by the Component. The Health Department has asked the AC workers to fill out an immunization history on each child at the inception of the program and the AC has agreed to comply. Implementation of the program is still awaited.

RELATIONSHIPS WITH FAMILIES

The Advocacy staff is now serving 173 families in their two target areas. They have recently had a number of persons ask to be considered "inactive." In some cases, families wished to be inactive because they felt that the Component had already helped them meet their needs. In other cases, families who had been assessed and were considered AC families, asked to be inactive because they had incomes in the range of $8,000 - $15,000/year and felt that they could manage their own needs. In all cases, the workers maintain contact with the family and are accessible should the family need assistance at a later date.

As it turned out, the higher income families who asked to be inactive, held jobs in the community such as school principal or director of parks. Although they are people who may not need the services of the AC, the home visit and needs assessment did introduce the program and did elicit from them verbal agreements of cooperation should the Component ever need their aid.

Workers make monthly home visits to each on-going family even if a specific referral is not being made for them. These visits serve to reinforce, in the family's mind, the concern of the Component and afford the workers the opportunity to check on any problems that may need their attention. As telephones are rarely found in AC homes, and if found are party lines of 8 to 12 families, home visits are really the only means of maintaining contact and re-evaluating a family's needs.

Every now and then a letter is received from a family needing assistance, but this is rare. The Coordinator did receive a rather touching letter from a tenth grader. It arrived at the office soon after the announcement of the $100,000 appropriation for Advocacy was made public. The girl was asking for a job and wrote the following:

> "My parents are on Welfare, my step-father has a total disability, and what they draw is barely enough to make ends meet. If I can get work or help someway (sic) just to buy my school clothing it would be greatly appreciated. Most of the school kids who work on your PCC are no older than I am. I need it just as bad or worse than they do."

The girl could not be hired to work at the AC, but the Coordinator made a special effort to see that she received help. He visited her at home and then went to speak to a counselor at her school. Between the Coordinator and the school, a part-time job was found for this young girl.

Workers seemed to know the families within their catchment areas. They were aware of existing problems and could confer with one another about specific cases without relating an entire history beforehand.

Speaking of the relationship between the AC and its families, the Coordinator has said, "We have instilled a trust in them. They now tell us things that they didn't in the beginning."

Referrals

The Coordinator estimates that well over 50% of all referrals have resulted in a specific outcome, although more referrals have been made than would be expected from this estimate.

The Coordinator reported that approximately 5 - 10% of all referrals made by the workers were not carried out by the families. The percentage is low because the Outreach workers provide transportation for most of their referrals.

Even so, there are times when transportation is arranged, the Outreach worker arrives at the home and the mother says she cannot go for her appointment because she does not have a babysitter. The majority of "no-shows" are due to lack of babysitters.

Although the percentage is low, a missed appointment is still a frustration. The Coordinator feels that this frustration is a function of the nature of the families the AC serves. "They can't always see that they have to be a certain place at a certain time. They don't understand the conditions under which we labor. They don't understand the coordination that takes place to get an appointment."

All referrals to agencies are made by the outreach team that is working with the family. The Coordinator often works closely with several families and makes his own referrals.

Follow-up

Follow-up to referrals is done to both individual and agency. In cases where the AC staff provides transportation, immediate follow-up is provided. Other cases call for a home visit, and a telephone call to the agency.

High-risk and/or multi-problem families

The Coordinator defines a high-risk family as "one that has problems and doesn't realize it. Sanitation doesn't bother them, no windows doesn't bother them, use of outside plumbing doesn't bother them."

As an example of a high-risk family, the Coordinator relates the history of an intact family with six children. The mother is a tuberculosis patient and the father has black lung disease and is 85% blind. The father's disability check is the family's source of income. The children are eligible for PCC, but cannot be enrolled until they have been examined by a doctor. The mother refuses to cooperate, she says that she and the children are all right.

FAMILY GROUP PARTICIPATION

Mass participation by Advocacy families is most difficult in this area. In the first place, transportation is an overwhelming problem. With a shortage of available vehicles and poor roads it is hard to mobilize people. Secondly, the population is not particularly cohesive nor active. The residents of Crum are just awakening to the need and benefit of community organization. Crum has recently held a number of PCC parents' meetings with turnouts of 20 or more persons. The Outreach workers in Harts say that Crum has made these gains because they have a resident who is a "political activist," whereas Harts does not.

Mass meetings

The Huntington Advocacy Component has held two mass meetings for its families, one in each catchment area. The meetings were called in order to inform families of black lung benefits and the Food Stamp Program guidelines that are available. Families were given legal advice on how to file for benefits and were told what the eligibility requirements actually were. Thirty-seven AC and PCC families attended these meetings, a large turnout for a rural area.

The residents of Crum called a meeting of approximately 10 families to discuss the water and sewage systems in the area. The water system in the local school was inadequate and had very low pressure. Although this was not a meeting organized by the Advocacy Component, it was taken as an opportunity to discuss the Advocacy program with the community. The PCC Director and Advocacy Coordinator spoke on the Advocacy Component at a Crum PTA meeting in August.

Committees

No committees of Advocacy families have been formed. The Coordinator is planning to hire a Program Planner next spring and hopes that once such a person is hired, there will be more activities and groups in which families will be able to participate.

On-going groups

Once again, there have been no groups formed, but with the advent of a Program Planner such groups may be organized.

RELATIONSHIPS WITH COMMUNITY RESOURCES

Contractual agreements

There have been no formal contractual agreements made between the AC and other resources. The PCC, however, does have a contract with the Lincoln County Health Department. The Department is contracted to do dental work on a certain number of children per month. If the PCC is unable to fill all the monthly slots then Advocacy children are allowed to receive service.

Referrals from other agencies

The Wayne County Department of Welfare has called upon the Advocacy Component to use them not so much as a resource for a client, but as a manpower resource for themselves. The Department's head has called the Coordinator to ask him to have one of his Outreach workers check on a family. Usually this check involves finding out if the family has food or a source of income. When the AC worker reports back, then Welfare sends out a caseworker to further investigate. The Coordinator states that Welfare does this because they do not have a large enough staff and that they usually only ask Advocacy staff to do this with families with which they know the AC workers are familiar.

In one instance, the process created a fairly serious problem. A family, after being investigated, lost its Welfare payments. The Welfare worker told the family that information obtained from the AC was the reason for the loss of income. This was a breach of confidence. The Coordinator took up the matter with Welfare, which was most apologetic. There has since been no recurrence.

The Wayne County Health Nurse has asked the Component to perform a similar duty. She called the AC to see if there was a worker available to check out a story about a snake bite. The AC complied.

The Welfare and Health offices are 25 miles away from the catchment area. A trip to Crum from Wayne may take a long time, depending on traveling conditions. There is the possibility that if AC staff did not perform these tasks neither would the Welfare Department nor the County Nurse. The Nurse, because of other commitments and the traveling time, might have decided that investigating a "story" of a snake bite was just not a priority when compared to other things.

On-going meetings

There are very few agencies in either catchment area so that on-going meetings are not that necessary. Linkages and cooperative relationships have formed between the Component and other community resources and close contact is maintained.

Coordination of agencies

There are no agencies that have coordinated with one another as a result of Advocacy efforts.

Changes in service delivery

As a result of Advocacy efforts, the Health Departments of both Wayne and Lincoln Counties have made changes in the manner in which they make immunizations available to the community. The Health Department had had a pre-scheduled immunization program whereby the County Health Nurse would spend an hour or two in a neighborhood doing immunizations. The AC and PCC began referring more children to the nurse than she could handle. The program made the Health Departments aware of the number of unimmunized children and the need for the nurses to come to the PCCs to administer shots. It was then agreed that the nurse would visit the Center once a month and see both PCC and AC children.

During a recent visit to the Harts Parent-Child Center, the PCC nurse called the Public Health Nurse to see if she could stay an extra hour during the next Immunization Clinic. It seemed that the previous month, when 22 children were brought in for shots, the 2-hour time allotment just wasn't enough.

The Public Health Nurse wasn't sure, at the time of the phone call, that she would be able to give the Center the extra time.

The Stella Fuller Foundation, a charitable organization has agreed to give priority to those families referred from the Advocacy Component. The agency provides clothing and household goods to families in need. If the Foundation does not have what the family wants, the family is placed on a mailing list and receives a card asking them to come in when the goods are obtained by the Agency.

An eye specialist from Huntington has agreed to see families with Welfare cards that are referred to him by the Component. Prior to this it was most difficult to have Welfare recipients receive this service.

The Coordinator has been meeting with State Welfare representative around the possibility of Welfare providing physical examinations for all Advocacy Children 0-5. He is now waiting to receive information regarding the constitution of the program and whether or not the AC is eligible.

The Coordinator, who did not have any relationships with agencies prior to taking the AC position, feels that he and his staff must be patient with agencies as well as with people. "They've got to know you well before you can have a mutual working relationship."

Although still working with agencies for improved relations, it is felt that the Welfare and Health Departments in both counties are faster to act than they were before.

"The Wayne County Welfare Department has said that we have relieved them of 50% of their workload in our target area. We've given them information that they cannot normally get. Maybe it should be the other way around, but people are getting much better service."

RELATIONSHIP BETWEEN AC AND PCC

The relationship that exists between the Huntington Parent-Child Center and its Advocacy Component is a very close one that structures every facet of the Component's work. In fact, in this setting Advocacy is genuinely a component of PCC and both are part and parcel of the same program. The Advocacy Component because of its additional staff has enabled PCC to pursue health and social service objectives to a far greater degree than was possible prior to the implementation of the Advocacy Component.

The PAC voted to include Advocacy families rather than to have a separate advisory group for Advocacy. The new plan calls for three (3) Center families and two(2) Advocacy families to be members of the PAC.

The Advocacy Outreach workers use the Parent-Child Centers as their base. They work closely with both PCC staff and PCC families. In turn, the PCC staff is available to Advocacy workers. In addition, both Center and AC staff share in joint staff meetings and in-service training.

PROGRAM OBJECTIVES

The following are the short-range objectives for the Huntington Advocacy Component.

- Develop walk-in mini community health centers using concept of multi-discipline health center.
- Comprehensive health program through National Health Service Corps (NHSC).
- Solicit medical manpower through National Health Service Corps.
- Develop linkages to specialty groups and hospital.
- Coordinate transportation to services.
- Establish guide document for all community resources.
- On-going education in health and nutrition.
- Staff training.

Develop walk-in mini community health centers using concept of multi-discipline health center.

In August of 1971, the PCC Director had submitted a proposal to the National Health Services Corps requesting two dentists to work in two mobile units in the PCC's two target areas. After the announcement of the institution of the Advocacy Component, the proposal was amended to include two doctors. Since that time plans have grown so that an actual clinic facility is on the drawing board.

In Wayne County, in which Crum is located, there is one (1) Public Health Doctor and two (2) Public Health Nurses to serve a population of 35,000.

In Lincoln County, in which Harts is located, there is one (1) Public Health Doctor and one (1) Public Health Nurse to serve 18,000 persons. Neither Crum nor Harts have any medical facilities in their immediate areas. The nearest doctor is 25 miles away. The need for health services seems obvious.

The Rural Medical Program (RMP) had agreed to put $40,000 into the Wayne County target area of Crum to assist the PCC with their plans for mobile medical units. It was then learned that the Ephraim McDowell Foundation had plans to construct a clinic in a county close to Wayne County. RMP informed the PCC Director of the Foundation's plans for their clinic and arranged a meeting between the PCC Director and a representative of Ephraim McDowell. The hope was to relocate the proposed clinic and have it put in the Crum area.

The PCC Director had several points with which she could bargain. First, the PCC already had $50,000; $10,000 of PCC monies that had been allocated for mobile units and $40,000 from the Rural Medical Program. Second, there was the possibility of receiving medical personnel from the National Health Services Corps, which will be further discussed in other objectives. Lastly, three new mines had opened in Kentucky, across the West Virginia border. This meant that plans could be arranged with the United Mineworkers Union to have the Union use the clinic as their health facility in the area. The Union would probably pre-pay the clinic, thus avoiding the possibility of the clinic being a financial risk to the Foundation.

The Foundation agreed to construct a five-modular unit clinic in Crum and to include a dental unit, something that the Foundation had never done before. It was further agreed that the Foundation would supply specialists and pharmacists on referral.

The clinic is due to open for operation January 15, 1973.

The clinic in the Harts area of Lincoln County faced different problems. There was the same $50,000 from PCC and RMP, but this time one Foundation was not enough to support the financial risk of locating a clinic in Harts. Money was finally secured from the Appalachian Regional Commission and Hygeia Facilities Foundation. In addition, the PCC Director went before the Board of Directors of the Lincoln County Opportunity Company to request that excess funds from their Emergency Food and Medical Program be reassigned to the proposed clinic. The Board agreed to reassign approximately $7,000. The AC Coordinator has found a site for the clinic that has been approved by all parties. Money and location are now in order, but there remains one important factor still to be arranged. The National Health Services Corps (NHSC) cannot supply the clinic with staff as yet.

Comprehensive health program through the National Health Service Corps.

This objective rested heavily on the attainment of personnel from NHSC. To date, the major thrust had been to get medical staff for the clinic.

Solicit medical manpower through National Health Service Corps.

The National Health Service Corps is a new federally-funded project whose purpose it is to supply medically needy communities with personnel. Doctors assigned to NHSC work for the project in lieu of doing military service. NHSC has now received such a large number of requests for doctors that they are having difficulty supplying communities with desired medical manpower.

In order for NHSC to provide an area with medical personnel, that community must be certified as medically needy. Certification must come from the local medical, dental and nursing societies.

The Medical Society gave its approval after a short waiting time. The local Dental and Nursing Societies, however, not being certain of just what NHSC was, refused to certify need.

The PCC/AC staffs worked extremely hard in the "campaign" for certification of need by attending meetings, getting front-page coverage in newspapers and using television spots to air their concern. In addition, patients, doctors and dentists who were friends of the program, applied pressure on their colleagues. During this period two PCC children died when they were unable to receive prompt medical attention. After three months of meetings and publicity, approval from all parties was gained.

While all of the above was on-going, the PCC Director had sent NHSC another amended proposal. This one requested two (2) doctors, two (2) dentists, two (2) dental hygienists and two (2) nurses.

The Appalachian Regional Committee may fund two nurses for the clinics. This is still in the planning stage. The nurses would be under the direct supervision of the physicians, but would work in conjunction with the AC and the clinic doing home visits, follow-up and medical evaluation.

The National Health Services Corps does not just assign personnel to a particular area, but allows personnel to chose their location from three sites. It is because of this choice that Crum has received a doctor and a dentist and Harts cannot get personnel. Two physicians from NHSC visited Harts, but for various reasons decided not to take on the position.

The latest communication from NHSC is that they do not think they can get medical personnel into Harts until July of 1973. This would indeed be a setback to the Clinic. There is a slight, ameliorating possibility that the Public Health Department will move a doctor over to NHSC so that the Clinic could open sooner, but nothing is definite at this time.

Develop linkages to specialty groups and hospital

A linkage with the Harris-Walker Clinic in South Williamson, Kentucky has been developed. The Clinic, which is a specialized group practice, will handle referrals from the proposed clinic in Crum. In addition, the Appalachian Regional Hospital in Williamson will also take referrals from Crum.

Linkage with the Crippled Children's Foundation has been developed and the Advocacy Component has used them as a resource for three of their families.

Establishment of agency linkages and those that would be of assistance to the Harts Clinic await the readiness of the facilities for operation.

Coordinate transportation to services.

The Advocacy Component staff tries to coordinate transportation with the PCC. If an AC family needs transportation, the Component tells them that they will be taken as soon as a PCC family needing this service is also going. "We won't run a trip for just one family unless it's an emergency."

The PCC Director has been speaking to persons from Southwestern Community Action Council about developing county-wide and cross county transportation systems. Although the need is obvious, this is a tremendous undertaking that is still only in the talking stage.

There is also the possibility that, within the next six months, the Crum area will be included in a transportation group that is now being organized. The groups would cover four counties, 2 in Kentucky and 2 in West Virginia. It would supply emergency medical transportation by ambulance. A number of ambulances would be stationed at certain points in each county and would be connected to each other and to medical facilities by radio communication devices. If effected, this would most certainly be an asset to a community that has almost nothing in the way of transportation services.

The Welfare Departments in both Wayne and Lincoln Counties have transportation aides who are supposed to bring clients to and from referrals. This does not begin to meet the acute transportation needs of these communities.

Establish guide document for all community resources.

The resources guide has been developed and printed, but is not quite ready for distribution.

On-going education in health and nutrition.

As the Coordinator explained the work being done in this area it appears not so much to be a program as it is an additional referral service. That is, the Parent-Child Center Nutritionist and Nurse are available to Advocacy families on referral from Outreach workers.

When asked to see a family, the Nurse does the necessary referrals for the family, schedules appointments with doctors and suggests literature. The Nutritionist plans meals for families that need assistance.

The availability of a nurse often eliminates transporting a child 25 miles to the doctor for a mild illness, but this cannot be characterized as on-going health education for AC families. An outreach consumer education program is in the planning stages to make this on-going education a reality.

Staff training

Once a week, the PCC and AC staffs have a joint staff meeting. Any particular problems regarding making contact with families, agency cooperation, recognition and scheduling are discussed. The Advocacy Coordinator and Center Directors meet with the staff.

Both Harts and Crum have a graduate student social worker in their programs. The students conduct weekly staff meetings and in-service training for the PCC family service workers and Advocacy staff. They also assist with the work schedules for each. The students essentially act as supervisors for the Outreach workers.

In-service training sessions are held once a month and are conducted by outside resource personnel. Most often these sessions follow a lecture format with a question and answer period. Representatives from the West Virginia Tech Housing Program, the County Welfare and Health Departments and the State OEO, have all presented lectures to the staff. Sessions are usually held for both PCC and AC staff, but this depends upon the nature of the presentation.

Marshall University, in Huntington, has recently begun a training program for its graduate students in special education and for the Advocacy staff. The students are being trained to work with Advocacy children who are "slow learners or emotionally troubled." This cognitive development program will be carried out by the students, but AC staff will be trained so that they can be of assistance.

A proposed Save the Children Federation program does not directly affect staff training, but will, by its presence, affect the program and the staff's development. Save the Children has submitted a proposal to the Youth Division of HEW to train 25 teenagers in the area of child development. Once trained, these teenagers will work in the Harts area with Advocacy children who cannot be placed in pre-school programs.

Summary of objectives

Health services are the major need in the catchment areas and indeed the PCC/AC is making strides toward providing these resources under extremely difficult conditions.

STAFF

Organization and background

The Coordinator has spent most of his life in West Virginia. He earned a master's degree in sociology from Marshall University and went to work in industry. Although living close to Huntington, the Coordinator was not aware of the available resources prior to taking the AC position. His previous job did not involve this type of community knowledge and so when he became Coordinator it was necessary for him to introduce himself to each agency.

The Coordinator does much of this work with agencies. In addition, he is more involved with families than are most other Advocacy Coordinators. He spends a fair amount of time in the field and is deeply concerned about those families with whom he works.

The two graduate students from the West Virginia School of Social Work are doing their field placement with the Component.

One of the students has taken a particular interest in the area of community mental health. He has been very involved with the resources in Wayne County and Huntington that deal with this problem and has been trying to place mentally retarded children in appropriate programs. He is attempting to do individual counseling with parents of troubled children, but is finding it difficult. "Parents of children with emotional problems may recognize the child's problem, but are not at the point where they can recognize the role they play in the problem."

The students will be with the program until December.

The Outreach workers are all community residents familiar with the people and the existing agencies. This knowledge of the community was a great asset in gaining entré to homes during the needs assessment survey.

Staff turnover

There have been no changes in the staff since the program's inception.

Staff training

This topic was discussed after objectives.

CASE STUDY SEPTEMBER, 1972

ADVOCACY COMPONENT
OF THE
JACKSONVILLE PARENT-CHILD CENTER

Principal Author: Dorie Greenspan

JACKSONVILLE, FLORIDA

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JACKSONVILLE

FAMILY CONTACT SUMMARY [1]

Number of different families telephoned for reason other than to schedule a home visit	114 [2]
Total telephone calls to families, May through September	154
Number of different families visited in the home	171 [2]
Total home visits to families, May through September	301
Number of needs assessments completed prior to May	268
Number of needs assessments completed since May	176
Total number of families dropping from "participation"	13

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[1] For period of May through September, 1972, inclusive.

[2] Total of monthly figures of different families contacted.

JACKSONVILLE

REPORT OF REFERRALS[1]

	Numbers
MEDICAL REFERRALS	
ALL MEDICAL (sub total)	216
PERCENT OF TOTAL REFERRALS	(60)
Prenatal care	27
Neonatal care	4
Nutrition	
Immunization	63
Check-up	36[2]
Medical coverage enrollment	64
Hospitalization	
Surgery	
First aid	1
Medical appliance	1
Family planning	18
Eye examination	
Hearing problem	
Speech problem	
Dental examination	
Dental problem	
Medical miscellaneous	2
PSYCHOLOGICAL REFERRALS	
ALL PSYCHOLOGICAL (sub total)	6
PERCENT OF TOTAL REFERRALS	(2)
Psychological testing	1
Retardation	3
Psychiatric care	
Developmental/behavioral problem	2
Psychological miscellaneous	
EDUCATIONAL REFERRALS	
ALL EDUCATIONAL (sub total)	7
PERCENT OF TOTAL REFERRALS	(2)
Adult basic education	
Private/special school enrollment	4
Facilitating transportation	
College or equivalent enrollment	
Head Start enrollment	3
Educational miscellaneous	

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[1] Totals reported for May through September, inclusive.

[2] Immunizations were given as part of enrollment in some cases.

JACKSONVILLE

EMPLOYMENT-RELATED REFERRALS

	Numbers
ALL EMPLOYMENT (sub total)	1
PERCENT OF TOTAL REFERRALS	(*)
Job rehabilitation	
Job training	
Job placement	1
Employment miscellaneous	

HOUSING REFERRALS

	Numbers
ALL HOUSING (sub total)	5
PERCENT OF TOTAL REFERRALS	(1)
Home repair/improvements	
Furniture/appliances	
Relocation (ruined quarters)	
Relocation (more space)	
Rent payment	
Eviction	2
Housing loan	
Pest control	
Housing miscellaneous	3

WELFARE REFERRALS

	Numbers
ALL WELFARE (sub total)	5
PERCENT OF TOTAL REFERRALS	(1)
Food stamps	2
Special welfare services	
Increased welfare payment	
Welfare enrollment	1
Veterans Admin./Social Security	
Welfare miscellaneous	2

MISCELLANEOUS REFERRALS

	Numbers
ALL MISCELLANEOUS (sub total)	123
PERCENT OF TOTAL REFERRALS	(34)
Help obtain clothing	3
PCC referral for enrollment	107
Legal problem	
General transportation	6
Day care	
Baby sitting	4
Help obtain emergency food	3
General information/miscellaneous	
TOTAL NUMBER OF RESOURCE CONTACTS	363 (100)

* Less than 0.5 percent.

THE COMMUNITY

The catchment area

The Jacksonville Advocacy Component (AC), whose offices are separate from those of the Parent Child Center (PCC), is housed in a duplex apartment, part of the city-administered Brentwood Housing Project. Brentwood occupies approximately one-third of the AC's mile-square catchment area; thus, their headquarters is accessible to the target population.

The area is a strange mixture of urban and rural. As the Acting Coordinator explained, Jacksonville is the most widely spread out city in the United States. The downtown area, approximately fifteen minutes' drive from the Component's office, is distinctly urban, with tall buildings and heavy traffic. The area between downtown and the housing project looks very much like a suburban residential area with large stucco homes and sprawling front lawns. The catchment area itself is rather a mix. Backyards face neighbors' backyards and clotheslines span the distance; sandy roads connect one line of apartments with another, while the paved streets wind in and out of the complex. Aside from the Brentwood project, which is itself low-rise, the remaining homes in the catchment area are single and multi-family dwellings. For the most part, homes in the area are fairly well maintained so that housing does not present a problem of consequence. The quiet, semi-rural appearance is broken by the very modern shopping center with its huge parking lot and the super expressway that cuts through the catchment area. A tall building here and there on the skyline accentuates the diversity which makes it very difficult to characterize the neighborhood.

September brings oppressive heat and humidity, and hoards of love bugs. The heat makes movement in the catchment area slow and one gets the picture of a lazy small town painted in pastel colors. Early in the morning, the area is alive with children on their way to school, but as soon as the bus picks them up, the neighborhood resumes the quiet that helps to pass the hot day away.

The target population

Approximately 1,527 families live within the catchment area. Three hundred eighty-eight of these families live in the 44 year-old housing project. Seventy-five percent of the population is black, and approximately two-fifths of the families are below the national poverty line. There are a total of 562 children between the ages of one and five, and 1,177 females of child bearing age in the catchment area.

This number of 1,177 represents females between the ages of ten and forty-four. Although the lower-bound age limit, ten years, seems extreme, the Bureau of Vital Statistics (part of the Division of Health) has reported an increase in the number of pregnancies among girls ages ten-thirteen since January, 1972. As will be discussed later, this fact becomes significant in terms of AC family planning program objectives.

THE NEEDS ASSESSMENT

The original needs assessment was done through a door-to-door survey. Information from the needs assessment has been carefully tabulated, and constitutes a basis for evaluating monthly progress. A new family moving into the area is assessed individually and their needs are added to the accumulated information. The Coordinator hopes to have a new needs assessment of the target area done in the near future. The data obtained from this survey would then be compared to the original data and used as a tool to measure progress in areas of concern.

Problems

The Coordinator has said that if the time schedule of the program had been different, he would have preferred to delay the needs assessment. Rather than to survey the area immediately, the Coordinator would have liked to meet with neighborhood leaders and community residents informally, to see just what they wanted from the program. This would have provided a degree of community input and involvement that might have made the needs assessment phase somewhat easier.

The problem which arose during the Jacksonville needs assessment was not that workers were turned away from people's homes during their survey; rather, the problem stemmed from respondents' reluctance to provide personal information during the first visit. In many cases, it was not until several visits had been made that a true picture of the family's case history emerged. Perhaps this problem would not have existed, had the community been more aware, initially, of just who and what the Advocacy Component was, and had community residents become involved with the AC goals.

Use of data

Despite the problem of establishing initial rapport and trust, the needs assessment did yield much useful information. As a direct result of data obtained from the survey, a new objective, Child Problems, was added to the Component's program. The survey identified 20 children in this category, which includes mental retardation, psychological problems, and the need for placement in special education classes.

Needs assessment information has been used by two community resources in addition to the Advocacy Component.

As a prelude to possible program expansion, Head Start came to the AC to learn of the number of four year-olds identified in the catchment area. The City Health Department took the number of pregnant women located in the area to use as a justification for the establishment of a new pre-natal, post-partum, and family planning clinic. The clinic is not yet operational, as adequate facilities have not been found.

RELATIONSHIPS WITH FAMILIES

The Advocacy Component staff works with 271 target families, that is, families for whom a referral has been made. This number may soon increase, as the PCC/AC catchment area may be broadened in order to provide more participants for the PCC. If this area expansion is approved, the AC workers will conduct a needs assessment of the families, and act as a recruiting agency for the PCC, in addition to recruiting new families for their part of the program.

All 271 AC families are seen by the Outreach Workers on a regular basis, usually once a month. That is, even when a referral is not in the process of being made, contact between worker and family is maintained. The regular home visits may be to follow-up on a previous referral, or it may be just to say hello and let the family know that the AC is still around and still caring. Women receiving pre-natal care are visited in their home once a week by workers who specialize in this area. Families whose children are scheduled for immunization appointments are visited at home or are telephoned to remind them of the appointment time. In addition to regular home visits, workers telephone each family once a month. It is estimated that approximately 20% of the families have called the AC at one time or another to ask for assistance or advice.

Referrals

The Coordinator estimates that 85% of the referrals made by the Component staff have resulted in the provision of service to the client, e.g., an immunization, a dental visit, etc. According to AC policy, successive visits to the clinic for a battery of immunizations, are not considered as separate referrals. When a child is enrolled in an immunization program, or when a pregnant woman is registered for pre-natal care, this is recorded as one referral,regardless of the number of visits the client may make to the agency. This policy results in a low number of reported referrals that may not truly represent the actual amount of work being done.

It is estimated that 15% of all referrals made by AC workers are not carried out by the families. The Coordinator credits this low figure to the understanding reached between worker and family prior to referral. A verbal contract between the two parties is worked out so that the client understands that the worker will do his part to see that the family gets service, but that the family must fulfill its end of the contract by keeping appointments and following through. This contract establishes a serious working relationship between client and worker at the outset. Responsibilities of both parties are made clear and each is free to confront the other should disappointment or dissatisfaction develop.

Follow-up to referrals

Follow-up on all referrals is made at both the agency and the individual level. A six copy agency referral form is completed for each referral, listing the agency making the referral, agency handling the referral, reason for referral, outcome, and client identification data. Copies of the form are retained by the agencies concerned and by the Community Planning Council, which coordinates all agency efforts in the Jacksonville area.

Individuals who fail to keep an appointment are contacted by their worker. Most often, appointments are not kept because of a lack of transportation or babysitters. If this is the case, an AC staff member supplies the needed support services. The Coordinator claims that, "We almost force people to keep appointments by leaving them no excuse for not showing up."

High-risk and/or multi-problem families

In commenting on the frustrating tendency of clients not to keep appointments, the Coordinator has said that a somewhat apathetic attitude toward seeking out service is "ingrained, inherited, and social. People are afraid of losing the little that they have. They're afraid of committing themselves because everytime they've committed themselves, they've been hurt."

Added to these attitudinal/emotional considerations is the fact that the majority of target families can be termed multi-problem families. It is the Coordinator's feeling that the multi-problem family usually has one serious problem that causes the others. His approach is to look at all problems to see how they are connected, rather than to study each problem individually.

As an example of a multi-problem family with whom the AC is working, The Coordinator cites a pregnant mother and her six children. The woman had been married once, but her husband was sent to jail for shooting her. She then lived with a boyfriend. The children, ranging in ages from four to twelve years, are the product of three different relationships and therefore have different surnames. The mother's concern is for her eight year-old daughter whom she thinks is "insane, a professional liar, and a nymphomaniac." According to the mother, the child does "strange things," draws horrifying pictures over the mother's bed and takes her clothes off. The mother is worried about her current pregnancy, is afraid that she will have another nymphomaniac, and would like to place the baby for adoption. She and the children are always sick. She cannot work when either she or the family is sick, so the rent cannot be paid. The more worried she is about her lack of money, the sicker she becomes and the more concerned she becomes about her daughter and her own pregnancy; and so the problems go full circle.

The Advocacy staff has worked with both the mother and the daughter in an attempt to provide counselling and referral services. Although the core problem seems to be with the mother, the staff has been able to do more work with the child. Presumably, the mother will eventually be reached through the daughter.

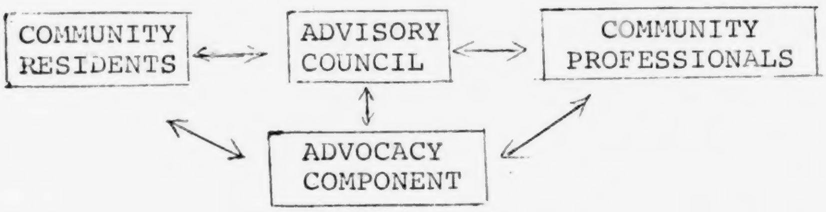
FAMILY GROUP PARTICIPATION

Mass meetings

The Jacksonville Advocacy Component has not held any mass meetings around particular issues. The Component does not currently have use of a sufficiently large meeting place, available in the evenings, the best time for such gatherings. Negotiations are now underway to secure a facility.

Committees

No committees of Advocacy families have as yet been formed. However, the Coordinator does have plans for a Committee Advisory Council. The AC's Advisory Council is composed of members of local agencies. The Coordinator feels that, at present, the Council is "kept in the dark," rendering it rather ineffective. What he would like to see is the creation of two additional committees that would relate to the present Advisory Council. The first committee would be made up of interested and concerned community residents; the second would be composed of professionals in the community. Both committees would include a specific number of persons who would be seated for a specified term, in addition to two seats that would always be open for additional persons, so that new ideas could be voiced. These committees would transmit information and ideas to the Advisory Council and to the AC. Graphically, the situation would look as follows:



The Coordinator feels that such an arrangement would make the Component truly responsive to, and aware of, the needs of its target population.

Ongoing groups

The AC staff has been both active and innovative with regard to planning and implementing a number of groups. For example, groups have been planned or actuated in the fields of immunization - well-baby, teen problems, and pre-natal care. A full description of the purpose and workings of the groups will be given in the sections of this report dealing with objectives.

RELATIONSHIP WITH COMMUNITY RESOURCES

The Advocacy Component appears to have developed cooperative linkages with a number of agencies. The Component seems to have established itself as a legitimate, viable force in the community, and to have earned the respect, recognition, and cooperation that such status entails.

In part, this relationship is probably due to the Component's posture in dealing with agencies. The Advocacy staff has tried to make it as easy as possible for agencies to work with them, so that both parties can better achieve their goals. The current problem with University Hospital points up this process.

University Hospital is the medical facility to which all pregnant women in the catchment area go to have their babies delivered, but it is not the hospital to which women go for pre-natal attention. This is not because the hospital does not offer a pre-natal care program, but rather because admission to the program is so "dehumanizing and demeaning" that women prefer to forego pre-natal care and deliver in the hospital's emergency room.

The intake procedure at University Hospital requires that the patient bring several forms with her and spend a great deal of time answering a pre-admission application. Very often, the woman does not have the complete battery of needed forms and so she is sent home, told to come another time with her papers, and required, once again, to wait for an interview. In cases where lack of forms is not the problem, answering the application questions is. One of the most embarrassing questions asks for the name of the woman's husband. In so many instances where there are no husbands, the woman is too ashamed to answer truthfully, and leaves knowing that she can have the child delivered by the hospital through its emergency services.

The population with which the AC works is geared toward crisis medical care, as contrasted with preventative medicine.

This being the case, when preventative care is made too difficult or uncomfortable to obtain, as in the above example, many people will reject the care rather than learn to work within the system.

The Advocacy Coordinator intends to deal with this problem by having his workers do the major portion of intake preparation. That is, the AC Outreach Worker will collect and check the necessary forms, prepare a case history, and see to it that patients are properly prepared for the initial interview. This will eliminate a good deal of waiting time, and somewhat ease the frustration and embarrassment caused by the procedure. To this end, the Coordinator is negotiating with University Hospital to set up a program in which Outreach Workers will be trained in intake and will be allowed to work inside the hospital. Planning is now ongoing.

In this instance, the Advocacy Component staff is not doing the work of the hospital, but is expediting service delivery. In addition, Outreach Workers are attempting to stress to their families the need to understand the procedures that agencies must use in order to serve people. They feel that it is important for persons to be educated to the responsibilities that they have which must be fulfilled in order to receive services.

Contractual agreements

To date, no formal contractual agreements have been made with other organizations. There is, however, money budgeted for contracts.

Greater Jacksonville's Economic Opportunity, the AC's CAP agency, must approve all contractual agreements made by the AC, and has agreed to let a contract that would provide dental services to Advocacy families. Presently, there is no dental service for indigents in this area, but pre-natal dental screening is done for the Component as an in-kind contribution. The contract has not, as yet, been activated, but the Coordinator plans to pursue the possibilities.

As mentioned earlier, the Jacksonville AC staff has been working with the City Health Department in a coordinated effort to create a new pre-natal clinic. During the planning stages, the AC offered the Health Department a contract through which the AC would pay one-half of the clinic nurse's salary. As facilities for the clinic have not been located, the contract has not been signed.

Referrals from other agencies

The Jacksonville AC has had four organizations refer approximately seventeen persons to them. The Division of

Family Services of the Department of Social Services has referred about a dozen people to the AC. In most cases, the referrals were for families with which the Division felt they could not properly work. Problems ranged from cases of child abuse to persons needing help in finding new homes. The Coordinator says the Advocacy Component is a last resort for the Division of Family Services; however, the fact remains that the AC was visible and active enough to be called upon.

Three exceptional children were referred to the AC by the School Board. The Board, feeling that the children were retarded, and uncertain as to what to do for them, referred them to the Advocacy Component. AC workers facilitated the testing of the children and had them placed in special classes.

The Child Guidance Clinic also referred a family to the AC. The mother of a public school child worked during the day and needed a means of providing care for the child after school hours. Staff was able to refer the mother for this service.

The most bizarre referral came from the Department of Immigration and Naturalization. A fourteen year-old girl from Kentucky, a runaway, was found in the catchment area and claimed to be an immigrant from Germany. It was a most confusing case, which did not really fall into the AC's domain; however, the Advocacy staff worked with the child, the local mental hospital, the city jail, and the Department of Immigration.

Ongoing meetings with other agencies

The Jacksonville Advocacy Component staff does not participate in any regularly scheduled meetings with other community resources on a policy-making level. The Coordinator does, however, maintain contact with other agencies and meets with administrative personnel on an as-needed basis to discuss problems, procedures, concerns, and new ideas.

Agency coordination

Jacksonville is served by the Community Planning Council which coordinates agency operations in the area. It is the Coordinator's opinion that to concentrate effort on agency integration would be a duplication of service. However, as a member of the Community Planning Council, the Component does have input and can work toward coordination, when necessary.

Changes in service delivery

As a result of Advocacy efforts, two agencies working within the catchment area have changed a portion of their procedures.

The City of Jacksonville Health Department maintains an immunization clinic in the area. As the Advocacy Component staff referred more and more children to the clinic, it became apparent that the three hour time allotment was not sufficient to handle all the children. The former AC Coordinator discussed the problem with the Public Health Nurse at the clinic. The nurse interceded on the AC's behalf, and was able to implement a change within two weeks. The hours are now extended to however long it takes to dispense immunizations to children with appointments.

The Child Guidance Clinic has also changed as a result of Advocacy efforts. Formerly, admission to a special program required testing, social evaluation, and a great deal of waiting time. The Advocacy staff met with the Child Guidance Clinic staff: within a month it was decided that a child referred to the program by the AC would be admitted immediately. The Advocacy workers now conduct the social evaluation, where needed, and refer the child for testing by a qualified specialist; the waiting time for admission has been cut significantly. The clinic's acceptance of the Advocacy Component's evaluation is another sign of the program's acceptance in the community.

Despite success in these two important areas, the Coordinator still views agency change as a long, arduous, and time-consuming process. At this stage, while still trying to increase the sensitivity of agencies, the stress is on changing procedures, not structure. Until procedural changes are made, the staff is trying to educate families to the agencies in terms of what agencies require in order to give services. The thought is that by increasing family sensitivity to agencies, the families will be better able to negotiate the system and the agencies, in turn, will be able to better deliver services to an educated, responsible population. Change seems to be needed in both directions.

RELATIONSHIP OF AC TO PCC

The Jacksonville Parent-Child Center and the Advocacy Component have had their share of internal problems. The PCC has had to deal with both parent and personnel problems.

While the PCC was contending with these problems, conflicts arose over autonomy between the PCC and its Advocacy Component. What resulted was a misunderstanding regarding the Component's relationship to the PCC and the community.

THE PROGRAM IN PHASES

The Jacksonville Advocacy Component program is designed for implementation in three phases:

1. emergency
2. remedial
3. education

The emergency phase

This part of the program was designed to provide service delivery for needs or problems that were uncovered during the needs assessment survey. The Coordinator explained that when the Outreach Workers were first sent into the field to conduct needs assessments it was March, and they felt that they were late and behind schedule. For this reason, Workers made referrals at the time of the initial interview and were able to handle several serious and/or obvious needs immediately. Enrollment in clinics was also begun during this phase.

The remedial phase

The remedial phase involves follow-up, care of ongoing or longer term needs, group discussion sessions with Advocacy families. As will be discussed later, the staff's activities are largely in this area, at present, with the exception of emergency referrals done for new Advocacy clients.

The education phase

In the education phase, "the Advocates work themselves out of their jobs." During this final stage it is hoped that Advocacy families will need the Component workers only for occasional advice concerning which agency to contact, but that they will be well aware of the community resources and the proper method by which to deal with them. The staff will continue to work closely with local agencies during the educational phase.

This brief program outline forms the foundation upon which the day-to-day activities are built. It is understood that not every family will arrive at the point of self-advocacy at the same time.

PROGRAM OBJECTIVES

The Jacksonville Advocacy Component is concerned with five basic areas of need:

- pre-natal care
- family planning
- immunizations
- well-baby clinic
- child problems

The first four areas were written into the original funding proposal, prior to the initiation of the needs assessment. Following the assessment, the area of child problems, including mental retardation and emotional or psychological problems, was added as an objective.

Pre-natal care: identify needs, assist in counseling, transportation, referral.

The identification of pregnant women and their needs is an ongoing process begun during the initial needs assessment. As was mentioned previously, Outreach Workers were often unable to obtain complete information during their first interview, and this was particularly true with expectant mothers. Workers felt that women were embarrassed to admit that they were pregnant especially if they were expecting anything but their first child.

Some pregnant women were identified by Outreach Workers who set up information tables in the local shopping areas. Workers dispense information on the importance and availability of pre-natal care and attempt to enroll persons, on the spot, for pre-natal care appointments. Identification tactics at such a "stake-out" are often very informal. One worker is quoted as having said to a passing woman, "Hey baby, you look pregnant!" as a tactic not found in professional manuals, but one that did get the woman into a pre-natal care program.

The Jacksonville Advocacy Component has begun efforts to identify and work with pregnant teenagers. Guidance counsellors at both the local high and junior high schools have been asked to refer their pregnant teenagers to the Advocacy Component. Thus, the Component will be able to make the necessary health referrals, to offer support services, and to maintain regular group "rap" sessions.

"Rap" sessions are a technique which the AC plans to employ more frequently in coming months. One such session was held recently as a trial effort. Eight "vocal" pregnant women were invited to the Component's office to spend an evening discussing the merit and importance of setting up talk groups. The session was led by the AC's two pre-natal specialists, who had been trained in this field by the local Red Cross. Feelings about pregnancy, complaints and praise for hospital service, the need for early medical attention, were discussed. The end result was the plan to conduct similar sessions twice a month for expectant mothers.

The projected sessions may not always assume a group discussion format. Some sessions may serve as a vehicle for dissemination of relevant information, or for the showing of films. In the planning stages now are a series of sessions to be conducted by a nutritionist and a Red Cross staff member, in conjunction with the AC. These would be home education courses covering such subjects as pre-natal care and nutrition, including shopping and formula preparation.

Pregnant women are treated as a very special group, and the Outreach Workers in this field try to visit each woman at least once a week. In addition, the workers ensure that every woman is provided with transportation. Although Jacksonville is considered an urban center, its public transportation system is meagre and unreliable. There is a bus system, but its scheduled runs are infrequent. Workers try to arrange transportation for pre-natal care appointments through friends and neighbors, but where this is not feasible, the worker provides transportation herself.

Aside from being visited every week by the AC worker, the mother is visited again once she is in the hospital for delivery. Here the worker has a captive audience. In the hospital, the worker discusses the importance of post-partum care, enrollment in a well-baby clinic, proper diet for the baby, and the availability of family planning services should the mother desire them. It is felt that this is an ideal time to discuss such matters, as the mother, just having had her child, is at the point of being most concerned. Most often, she is also very pleased to have a friendly visitor.

On the drawing board in this area are the pre-natal care clinic, the improved relationship with University Hospital, and a "Swap Shop" for maternity clothes.

Both the clinic and the relationship with University Hospital have been discussed earlier; there are, however, some additional points to be made. The clinic, to be set up in the Brentwood area, does not represent a duplication of efforts made by the hospitals and city clinics, but rather, is an expansion of services. The proposed clinic would be a resource for pregnant women who work during the day and who therefore cannot keep appointments at the other agencies. Also, the clinic would work very closely with the City Health Department, and would hopefully have an arrangement with University Hospital and St. Vincent's Hospital so that the hospitals would deliver the babies for the clinic.

Setting up the clinic does not make the need for changes in University Hospital's pre-natal care intake procedure unnecessary. University Hospital would still be used as a resource for pre-natal care once the clinic is established.

The idea of the maternity "swap shop" is to set up a location to which pregnant women and mothers can come to obtain used baby and maternity clothing. To date, church organizations have agreed to donate infant clothing; mothers who already have children have promised clothing, and Advocacy staff and friends have made donations. In addition, it is hoped that the Component will be able to solicit the use of PCC space for the project, as well as the use of PCC sewing machines (during shop hours) so that women will be able to make their own clothing.

It is the staff's idea to fulfill all priority goals as quickly and efficiently as possible, and to allow time during and after achievement of objectives for "amenities." The maternity "swap shop" will help mothers to obtained much-needed clothing. However, it could not be established unless the workers felt they were moving steadily toward achievement of their primary objective in this area.

Family planning: identify family units, provide information, motivational efforts.

Family planning is the natural follow-up to the pre-natal care objective. As mentioned, once the baby is born, the family planning unit moves in. Both teams of specialists work together for the mother and her family's welfare.

During the needs assessment phase, very little was done in terms of actual identification of persons interested in family planning. A few persons wanting such services were identified, "by accident," and were then referred to the proper agencies.

The city of Jacksonville has an efficient Planned Parenthood organization as well as city clinics offering family planning services. These groups serve most persons in the target population requesting their aid, so the area is well covered. Where family planning becomes a major concern is not with older persons, but with the teenage population in the catchment area.

As has been noted, there has been a sharp increase in the number of teenage pregnancies, so it is to this group that the AC staff has addressed its attention. Although teenagers are not technically within the AC's domain, the Component staff has termed young adolescents "potential pre-natals" and feels a responsibility to work with them.

The two Outreach Workers in the family planning area were trained by the local Planned Parenthood agency. The vehicle they have used to attract participation and disseminate information has been again the "rap" sessions. During the month of August, four (4) such Human Sexuality rap sessions, as they are called, were held with an average of fifteen (15) adolescents in attendance. The sessions are sometimes structured, with guest speakers or several topics discussed with supplementary talk aides, or they can be an open forum for far-ranging conversations. The point is always the same: to establish among adolescents a better understanding of their sexuality and their responsibilities to themselves and others, and to increase their awareness of the services available to them. The sessions also provide an opportunity for teenagers to communicate with one another on a level that is different from within the classroom or a casual street meeting. Referrals to appropriate agencies and enrollment in planning clinics grow out of these sessions.

During the last session, the group asked if they could have a session on drugs. The Outreach Workers first thought these adolescents knew so much about drugs that there was little they could be taught. It turned out that information was badly needed regarding drug treatment. The Worker has contacted a local drug abuse agency and is now planning a future session. Sessions on venereal disease are also in the planning stages.

During a recent visit, Outreach Workers were enthusiastically discussing plans for a family planning "sock hop." This would be an after-school dance with refreshments for adolescents. It was hoped that the dance would attract adolescents not already involved in the "rap" sessions, and then serve as a means for further introducing the Advocacy

Component to this segment of the population. Names and addresses of those attending the dance would be taken and workers would then follow-up with a home visit, a needs assessment, and hopefully an enrollment in future group sessions.

The dance is to be held in space donated by the Neighborhood Community Center. Negotiations are underway with the Community Center to use their space for the "rap" sessions. With the group growing in numbers, space at the AC office is becoming a problem.

These sessions and the concomitant in family planning programs should make an impact on the number of teenage pregnancies. However, when pregnancies do occur, the adolescents will be more aware of the available relevant agencies in the area, as well as of the assistance the AC can offer.

An interesting sideline to this part of the program is the attitude of the parents of the teenagers with whom the staff is working. For the most part parents are unwilling to discuss with AC workers the possibility of their children engaging in sexual activity. The prevailing attitude was one of, "not my child." This also meant that parents were unwilling to discuss family planning methods with their children. However, although parents will not discuss these matters with their families, not one parent has voiced an objection to the Advocacy Component personnel doing so.

Immunizations: identify needs, provide information, establish clinic relations, recordkeeping system.

"These are the easiest referrals to make." To have all children in the catchment area, ages 0-5, immunized was a priority objective of this program, and steady progress has been made toward achievement of this goal.

Children in need of immunizations were identified in the initial needs assessment. However, identification is an ongoing process. As a new child is found, procedures for enrollment in an immunization program are begun immediately. Identification is facilitated by the Brentwood Housing Department which sends a list of all new tenents in the project to the PCC. It is projected that by December, 1972, all children in the catchment area will either have completed, or at least be in the midst of, the immunization series.

As previously mentioned, hours of the immunization clinic have been extended. In the future, the Component staff hopes to convince the City Health Department to include testing for sickle cell anemia, iron deficiencies, and worms. If such becomes available, the AC workers would make certain that all those children for whom immunizations had begun would also be given tests.

Advocacy workers facilitate the provision of support services: babysitting and transportation, to assure that immunization appointments are kept. Each parent whose child has an upcoming appointment receives either a postcard, a telephone call, or a home visit as a reminder.

Follow-up contact is maintained until all children have completed their shots. One week during the summer, an experiment was run; AC workers did not remind parents of appointments. Unfortunately, only nine of the scheduled twenty-three appointments were kept. Although this was a disappointment to the workers in this area, it has pointed up to them the continuing need to emphasize the importance of proper and preventive medical care as well as the responsibility that the mother has to her child, to the clinic which has set aside time for her, and to the worker who has expended a great deal of effort. A similar experiment will be run in the future, as a measure of progress in the area of parent education. In an additional effort to motivate concern on the part of parents, the workers have begun "coffees;" discussion groups. These are held in conjunction with well-baby services and will be discussed under that topic.

Establishing a record-keeping system is an ongoing project.

The two goals in this area are the maintenance of (1) a directory, and (2) immunization cards. The directory would list all children in the area who have completed or are receiving the immunization series. The directory is expected to be completed by December 1972. Maintaining immunization cards is constantly ongoing. These are cards showing the immunization, the date received, and are in conformity with School Board requirements for children first entering school.

Well-baby clinic: establish referral system, provide information, recordkeeping, follow-through.

The Well-baby and Immunization Specialists work as an integrated team to motivate parents' concern fo the health of their children, to provide information, support, and services when needed.

The Specialists in this field would like to enroll all new-borns in the target area in the well-baby clinic. To this end, identification of babies is an ongoing process. The original needs assessment identified some babies in needs of these services, and the workers are continuing contact with families by telephone, through a door-to-door survey, and through referrals from workers at other community agencies.

The Component's own Pre-natal Workers are a valuable source of referrals. Immunization and well-baby care are the natural follow-up to pre-natal services. In addition, the well-baby workers visit mothers in the post-natal ward along with the re-natal Specialists.

When workers begin making referrals for well-baby services, they discovered that the clinic in the area was running at less than fifty percent capacity. Although the clinic could provide twenty-five appointments for the one day a month during which it was open; only nine appointments were made, on the average. Babies were getting medical attention, but it seems that parents were taking their children outside of the catchment area to another clinic for service. The Coordinator's explanation was, "they had forgotten it was here."

Be that as it may, the Component's staff is now making a concerted effort to register babies for service at the Brentwood Clinic. In addition, the Coordinator plans to meet with the well-baby nurse to discuss the need and possibility of extending clinic hours to at least two days a month. To date, five babies have been unable to receive care as a result of the short clinic hours. It is also hoped that he will be able to show the clinic the need for hiring a second nurse, so no child will have to be refused service.

During the month of August, the Immunization and Well-baby Specialists worked to arrange a "coffee," or group discussion, for eleven mothers. As this was to be a test session, the workers invited their most "vocal" clients. The meeting was called in an effort to tap ideas of mothers as to the best methods with which to educate other, less concerned parents, and to the need for preventive medical care for children. Again, as with the pre-natal session, the discussion was to give workers insight into the experiences these people have had with medical facilities, as well as their feelings about the needs of their children. All this was discussed during the meeting, as were many ideas regarding the types of activity and involvement in which the Advocacy program should and could partake.

This particular meeting became rather a marathon, lasting four and one-half hours, sending mothers home late,and creating somewhat of a peculiar problem. Advocacy staff video tapes every "rap" session so tapes can be used as reference and, more important, as a tool for diagnosis and staff training. With this session lasting so long, the staff exhausted their available supply of video tape.

Further meetings, with a more structured agenda, are being planned now that community input has been obtained. Meetings will probably be held twice a month, beginning in November, and it is hoped that the Red Cross nurse will be able to attend these sessions.

There is also another type of session in the planning stages. These sessions would include mothers who have one baby and would like to finish school. The Advocacy staff feels there are mothers in the community who left school to have a child, and fear that it would be too difficult to be both a mother and a student. These sessions, then, would serve a number of functions; they would provide information on maternal and child care; they would provide motivation and support to those women interested in returning to school; they would make women more aware of the agencies available to them; and they would provide opportunities for persons in similar situations to discuss their difficulties and hopefully to learn from, and be encouraged by, each other.

The "rap" session is not the only motivation-building technique used by the AC staff. Advocacy workers make home visits to mothers as soon as they return from the hospital with their babies. During these visits, the worker assists the mother in bathing and feeding the child, encourages her to attend the "rap" sessions, and emphasizes the great importance of making certain the child attends the well-baby clinic regularly, and is immunized. It is hoped that the Red Cross nurse will accompany Advocacy workers during future home visits.

In terms of recordkeeping, workers go to University Hospital at the time when babies are transferred from the delivery hospital to the clinic that will be providing well-baby care, and bring the hospital records to the target area's clinic. Other than this, recordkeeping seems to be similar in all areas. That is, referral forms are completed and mailed to appropriate agencies, and workers maintain files on each child, keeping running tabulations on the number of children seen and those needing appointments.

Parents whose children have scheduled appointments are notified by postcard, telephone call, or home visit. Should transportation or babysitting be necessary, the staff attempts to facilitate provision of these services.

Child problems

In this field, the Advocacy Component staff works not only with children under five, but with these children's older siblings. The rationale for this is that the target children (ages 0-5) will be adversely affected by siblings with problems, both as a result of their relationship with their brothers and sisters, and by demands these children make on their mothers' time.

Workers are now initiating a screening program. This screening will be done in a small section of the catchment area and is planned for one hundred children. The Denver Developmental Screening Test and the Vineland Social Maturity Scale are being used. The Coordinator and the Child Problems Specialist have both been trained in the use of these instruments, by the Agency Coordinator for the Division of Retardation of Florida State, a psychologist. There will be no formal evaluation of screening results; however, should one of the testers feel that the test results indicate a need for follow-up, children will be referred to a psychologist or other qualified specialist for further testing.

This testing requires parental consent. To obtain permission for testing, workers visit the homes, explain to parents to need to utilize professional counsel, and attempt to encourage parents to comply.

This screening process serves two functions. First, it helps to identify children in the area in need of this type of assistance. Second, screening expedites the referral process. Presently, low-income parents interested in having their children tested must usually use public services. The waiting list for appointments to these services is long as is, perforce, the time between identification of the problem and contact with an appropriate referral agency.

It will now take less time for a child to be enrolled in an exceptional child program. Previously, enrollment was delayed because of the waiting list for testing. Now, a child can be tested by a Child Advocate and a certified psychologist, a complete social history can be done by the AC staff, and the child can be presented to the program for immediate acceptance.

Although at the start, only a segment of the population will be screened, the Coordinator plans to sensitize all families in the catchment area to the existence of child problems and of the agencies that can handle these problems. Home visits will be made, so the importance of early detection of these problems can be stressed. In addition, the Coordinator intends to hold group discussions in this field and develop a directory of mental health resource in the area.

Summary of objectives

The Child Advocate recently said that during the last few months' difficulties, the AC activity level had fallen. This may be so, but the fact is that progress is being made. Referrals are completed, families are seen at home, innovative plans are being generated, children are receiving medical care, and resources are being mobilized, agencies are cooperating.

THE STAFF

This program's staff is organized along three levels:

the Coordinator, the Lead Child Advocate Worker and Child Advocate Workers, or Specialists.

The former Lead Child Advocate Worker is now Acting Coordinator. He is a native of Jacksonville and has received a B.A. in political economy from Johns Hopkins University.

The Lead Advocate Worker's responsibilities were to act as liaison between Coordinator and staff, organize the recordkeeping and filing system, coordinate statistical information, arrange appointments with agencies, and act as trouble-shooter when Outreach staff members had difficulty handling a case. In addition, he very often accompanied the original Coordinator to meetings with agencies.

The seven Child Advocate Workers are termed "Specialists" and have been especially trained for their tasks by community agency personnel. All workers are community people; for four of them, this Outreach position represents their first job.

Three Outreach Specialists are presently enrolled in course work that will lead to the bachelor's degree. A fourth worker is interested in finishing her high school education and is planning to make arrangements for enrollment.

Staff training

During the initial stages of the program, agency personnel conducted in-service training sessions. This practice has stopped, but plans are in the making to begin such sessions again shortly.

At present, staff meetings and evaluation are ongoing. Staff meetings are held once a week, during which time general problems of the Component are discussed and new information is disseminated. The Coordinator is available to all workers for conferences on methods of handling difficult cases, for suggestions on appropriate referrals, and for any other help that might be needed. Occasionally, he chooses case files, at random, and checks them to make certain everything is up to date and in order.

Staff turnover

In the course of the program, two persons have resigned from their positions. One Outreach Worker left when she became pregnant; her position has been filled. The other person, the original Coordinator, moved to another city.

General comments on staff

The Coordinator has said of his staff, "What they lack in professionalism, they make up in enthusiasm." Indeed, the staff's enthusiasm is noteworthy. During an informal staff meeting at the end of the day, workers were discussing plans for the upcoming "sock hop." The excitement generated was contagious. One gets the feeling that these people really care about the families with whom they work and about the quality of the job they do. They seem interested in new ideas, in new techniques for reaching families, and in new and better methods of motivating their families.

The staff may have difficulty understanding business procedures and writing reports, as the Coordinator suggests, but they are concerned about their program. When GJEO was holding an exhibit of community agencies and it was necessary for the AC to mount a display, the staff worked the regular full day and then worked on the display until late in the evenings, sometimes until midnight. The Child Advocacy Component took first prize.

CASE STUDY SEPTEMBER, 1972

ADVOCACY COMPONENT
OF THE
LA JUNTA PARENT-CHILD CENTER

Principal Author: Jim Schwartz

LA JUNTA, COLORADO

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LA JUNTA

FAMILY CONTACT SUMMARY [1]

Number of different families telephoned for reason other than to schedule a home visit	3 [2]
Total telephone calls to families, May through September	3
Number of different families visited in the home	75 [2]
Total home visits to families, May through September	126
Number of needs assessments completed prior to May	58
Number of needs assessments completed since May	127
Total number of families dropping from "participation"	10

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[1] For period of May through September, 1972, inclusive.

[2] Total of monthly figures of different families contacted.

LA JUNTA

REPORT OF REFERRALS[1]

	Numbers
MEDICAL REFERRALS	
ALL MEDICAL (sub total)	9
PERCENT OF TOTAL REFERRALS	(18)
Prenatal care	
Neonatal care	
Nutrition	
Immunization	
Check-up	
Medical coverage enrollment	
Hospitalization	2
Surgery	1
First aid	
Medical appliance	
Family planning	
Eye examination	1
Hearing problem	1
Speech problem	1
Dental examination	
Dental problem	
Medical miscellaneous	3
PSYCHOLOGICAL REFERRALS	
ALL PSYCHOLOGICAL (sub total)	6
PERCENT OF TOTAL REFERRALS	(12)
Psychological testing	
Retardation	1
Psychiatric care	3
Developmental/behavioral problem	2
Psychological miscellaneous	
EDUCATIONAL REFERRALS	
ALL EDUCATIONAL (sub total)	1
PERCENT OF TOTAL REFERRALS	(2)
Adult basic education	
Private/special school enrollment	1
Facilitating transportation	
College or equivalent enrollment	
Head Start enrollment	
Educational miscellaneous	

---

[1] Totals reported for May through September, inclusive.

LA JUNTA

	Numbers
EMPLOYMENT-RELATED REFERRALS	
ALL EMPLOYMENT (sub total)	1
PERCENT OF TOTAL REFERRALS	(2)
Job rehabilitation	
Job training	
Job placement	
Employment miscellaneous	1
HOUSING REFERRALS	
ALL HOUSING (sub total)	11
PERCENT OF TOTAL REFERRALS	(23)
Home repair/improvements	4
Furniture/appliances	
Relocation (ruined quarters)	1
Relocation (more space)	3
Rent payment	
Eviction	
Housing loan	2
Pest control	1
Housing miscellaneous	
WELFARE REFERRALS	
ALL WELFARE (sub total)	12
PERCENT OF TOTAL REFERRALS	(25)
Food stamps	3
Special welfare services	5
Increased welfare payment	2
Welfare enrollment	
Veterans Admin./Social Security	1
Welfare miscellaneous	1
MISCELLANEOUS REFERRALS	
ALL MISCELLANEOUS (sub total)	9
PERCENT OF TOTAL REFERRALS	(18)
Help obtain clothing	
PCC referral for enrollment	1
Legal problem	6
General transportation	
Day care	
Baby sitting	
Help obtain emergency food	
General information/miscellaneous	2
TOTAL NUMBER OF RESOURCE CONTACTS	49 (100)

THE COMMUNITY

Catchment area

The central PCC office, and the AC office, are in the same quarters, located in the basement of a building off the courthouse square in La Junta. Since this space is not sufficient to meet the needs of the AC, new office space, in the same building, has been acquired. Within one to two months it is hoped the area will be fully decorated and functioning.

The program serves the tri-county area of Bent, Crowley, and Otero Counties. This large rural area in southeastern Colorado contains major poverty areas. It is clearly an out-migration area, evidenced by a five percent reduction in population between the 1960 and 1970 censuses.

There are four major towns in the tri-county area: Ordway, Rocky Ford, Las Animas, and La Junta. La Junta, with a population of 12,000, is fairly typical of most small rural towns in the area. In a centrally situated square in the heart of the small business district is the court house. Almost all residential streets in the non-poverty areas are tree lined, with many well kept lawns. La Junta is situated on the Arkansas River, with the industrial section north of the river, and the business and residential area to its south. The Santa Fe Railroad junction is located next to the river, and the rails are still used for transporting grains and feeds.

La Junta is a church-going town: churches are to be seen every few blocks. A number of parks dot the area. Otero Junior College, with approximately 1,000 students, is housed on an attractive new campus situated on the south side of town. Otero Junior College presently offers a two-year degree in a number of disciplines.

A federally-funded housing project for 70 families, Morningside Heights, was recently completed. While it strikes the casual visitor as being a relatively pleasant spot to reside, the Director of the Advocacy Component has observed, however, that it will turn into a slum within a short time. There are no paved streets as yet, and during the rainy season this becomes a serious danger. The greenery is extremely sparse. Items still remain from the construction period, e.g., uncovered cables are a danger to children. No area was designed in the project for recreation or play for either children or adults. Cheap and shoddy material was used in the construction of the project, and within less than a year, snakes, scorpions and rodents are already a significant problem. There is only one washing machine for the whole project.

Once past the middle class section of town, well-kept paved roads suddenly become rutted dirt: the Chicano barrio. A slum. Little or no greenery. Shacks. Refuse. "Homes" with windows covered by newspapers to keep the hot sun out. Rotting or dirt floors. Sagging roofs. Chipped and unpainted walls. Rodents. Bugs. Many buildings with low ceilings less than 60 inches from the floor. This is where much of the AC's target population resides.

Target population

Twenty-six percent of area families receive an income of less than $3,000, and another nineteen percent earn less than $5,000 annually. The high school dropout rate is 22%. The average family size in the catchment area is 5.2, contrasted with the total population average family size of 3.1.

Chicano life and culture is a significant factor in the area, particularly for the social service agencies. Only 25% of the total population is Spanish-surnamed; however, 85% of the families served by the PCC are of Chicano origin.

NEEDS ASSESSMENT

The original AC needs assessment survey was conducted by two AC staff members in January 1972, among 20 families selected at random from the catchment area. There was no structured questionnaire and no notes were taken during this visit.

The second visit to each family was made by the resource specialist, and the Advocacy Coordinator, i.e., one male and one female. The presence of the female staff member at the home visit apparently made considerable difference. Female interviewees were purportedly more willing to divulge personal information to combined male and female interviewers than they were to two male interviewers.

The needs assessment (which is defined as visiting families to evaluate their situation) is an ongoing process in all four areas. The Coordinator said the needs assessment is continuing so that the AC staff can become aware of total community needs and have an opportunity to meet families. Ultimately, she said, the AC hopes to have a complete picture of the area, which will be useful in producing changes in the Health and Welfare Departments and improving housing conditions locally.

The AC resource specialist explained needs assessment to be the "total number of families contacted to have their needs assessed, but did not necessarily mean that the interview was completed in every case." He explained that follow-ups were "visits to families after their needs have been assessed."

The La Junta AC staff has completed needs assessments on 184 families. Of these families, 40 have received some type of concrete assistance from the Component staff. That is, since January 1972, Advocate aides have helped 40 families with problems in areas such as health, welfare, housing, or legal aid.

Most of the families assessed and referred are from Rocky Ford, Las Animas, and Ordway. La Junta has only recently been included in the AC's catchment area.

With respect to the results of this needs assessment, the Coordinator has written:

> "Highest priority need according to assessment results is emotional security. This verifies our past findings and intuitive judgment based on our experience with poverty families.
>
> "We also recognize that emotional stability of the child is affected by the parent's ability to control or cope in other categories listed in the needs assessment. Therefore it is reasonable to assume that to the extent needs are met in any category there will very probably be some improvement in the emotional stability of the child."

The first needs assessment visit did not uncover many problems and needs. In the same sense, viewing the needs assessment as an ongoing outreach activity, the second visit was considered inadequate for final, total needs assessment. Priorities are changed as a function of the monthly needs assessment; thus the priorities themselves change from month to month. For example, in August, dental care was given highest priority, because it was found that some children were not receiving adequate dental attention due to the high cost and lack of qualified dentists in the area. The AC responded to this need by sponsoring a "Preventive Dentistry Day" which will be described later. Similarly, in September, the major need priority became to aid five families who lived in especially dilapidated housing. These families were helped to move into the low income housing project.

The latest phase in the needs assessment survey is scheduled for October. One hundred families from the La Junta area will be contacted, and interviewed, using a 40-question interview schedule. Children found to be most in need of attention will be given the Denver Developmental Screening Test and the Bayley Test of Infant Development, administered to them by specially-trained AC staff. Families thought to be needing further aid will be visited by professional staff from the JFK Child Development Center, in Denver. If necessary, the children then will be referred to the JFK Center, where children will be thoroughly diagnosed and treated.

Use of data

Information from the needs assessment has been used by other agencies. For instance, the Health Department used information in expanding clinic service. The AC voluntarily provided the Health Department with their monthly statistical compilation. As a result of this, in August, the clinics in both Rocky Ford and Ordway, extended their service from one to three days per month.

The Colorado Migrant Council used information from the needs assessment to help three Rocky Ford families get their legal status changed from migrants to area residents which enabled them to qualify for assistance from the Health and Welfare Departments.

The free medical clinic is sponsored once a month by volunteer doctors from Denver, who call the AC, and other local agencies, a short time before each clinic session to ask if there is any particular health problem for which they should prepare. The Coordinator said that in recent months only general practitioners and interns have come from Denver, but that she had requested services of a pediatrician and a dentist.

RELATIONSHIPS WITH FAMILIES

The AC staff works with approximately 50 families each month. Once a problem is resolved, the AC staff does not continue to contact the family each month.

There are different mechanisms used in maintaining contact with the families. Each family is sent a letter telling them exactly what the AC is, and who is on its staff. The seven outreach workers, four of whom are part-time, make approximately 50 visits per month. The outreach workers are encouraged to regularly telephone the families just to maintain contact. Each worker makes at least five calls per week, i.e., the seven staff members make at least 35 calls weekly. Similarly, families are encouraged to call the AC staff; as a result, almost 30% of the "month's families" called the AC in September.

Another method of contact with the families is to encourage their attendance at the local area Advocacy Council meetings. This two months old council is composed of the more than ten agencies servicing children in the catchment area, plus local business groups, and the Ministerial Alliance. Response to date is encouraging: 24 families attended the September council meeting.

Referrals

In September, 39 referrals were made to other agencies. Among these, 12 received the indicated service, three did not keep their appointments, and 24 referrals are reported to be in various stages of assistance, "awaiting action," etc. Follow-up to families is made after each referral, and in many cases the AC worker joins the family in going to the agency.

High risk and/or multi-problem families

Many, if not most, of the families that AC works with are multi-problem families. The Coordinator considers such a family to be one in which several offspring show evidence of physical or mental malfunctioning. Some of the common problems found in such families in the La Junta area include the following: slow/dull children; physical abnormalities; speech impediments; emotional instability of parents and neglected children who lack the basic necessities.

The Coordinator gave the following example of a multi-problem family:

The father is disabled and has recently undergone a back operation. The mother, an epileptic, had managed to work for a time, but has now become unemployed. Their young child, in poor health, has not been adequately fed or clothed. The family was in need of increased Welfare payments, but was told that such an increase would not be forthcoming for a month. In the interim, the family was having difficulty paying the amount needed for Food Stamps.

FAMILY GROUP PARTICIPATION

Mass meetings

One of the major thrusts of this AC is the organization of large scale events. In September alone, several meetings were either organized or supported by the AC.

The first "brush-in" at La Junta was an experience in preventive dentistry to allow children and parents to realize that care of the teeth will result in fewer excessive dental bills. The program involved a puppet show, educational films for different age levels, a speaker on nutrition and diet, a cooking demonstration on preparing quick snack treats, and the "brush-in" during which free toothbrushes and squares of fluoride paste were distributed. Some 40 agencies were contacted to encourage their members, clients, or associates to participate. In total, roughly 250 children and 50 adults attended the "brush-in" which was held at Otero Junior College.

The AC aided the Rocky Ford Housing Authority in sponsoring a meeting on adequate housing. The Coordinator estimates that almost two-thirds of the 60 people who attended came as a result of AC encouragement.

The AC received the film "Looking at Children" from the Metropolitan Life Insurance Company. It is designed to increase the observational abilities of teachers working with young children, so that they will be better able to identify possible health problems. Many community groups were offered the film for use. In total, more than 350 adults saw the film during the week it was available, including many teachers, college faculty, and PCC parents.

Two other films dealing with nutrition were also recently shown. They were: "What's For Dinner" and "Hey Cow." Eighty families in the housing project in La Junta, 15 families in a Rocky Ford Church, and 23 families in the Las Animas PCC viewed the films.

In August the AC sponsored a "Nutritional Thinking in Action" workshop at the junior college, which was a session devoted primarily to the importance of the quality of milk given to infants. A representative from Ross Laboratories served as the resource leader.

Also in August, a pre-natal workshop was held with the cooperation of Ross Laboratories. Twenty-eight women, 17 of them pregnant, attended the session. They discussed such issues as the significance of special nutrition, of visiting the proper medical specialist, the bodily changes occurring as a result of pregnancy, breast feeding, maternity clothes, sanitary matters and other related issues.

Committees

A tenant housing committee held its first (monthly) meeting on October 4; twenty-seven parents attended, representing 18 different families. One of the advocacy aides was elected president of the group, because she had organized the meeting by sending fliers to all 70 families in the housing project, and then personally knocked on every door to encourage people to attend. Two activities were decided upon. First, this committee will solicit bids for carpeting and tiling the cement floors in every apartment. The committee feels they are in a position to pressure the local housing manager, who is employed by HUD, to spend funds on such expenses. The second activity they will work on is to have fencing put around the entire housing project. The next housing meeting is set for the last Tuesday in October, at a grade school, and will include a Halloween party for children.

Ongoing groups

In September, four different groups of AC mothers met with AC staff and representatives from the Ministerial Alliance, to discuss such areas as birth control, feminine hygiene, and sex education. At least ten mothers attended each of these groups, which are scheduled to meet at least once a month.

A group of teenagers sponsored by the AC began in April to hold monthly rap sessions. Approximately 30 attend each session to discuss ways they might serve as youth advocates. In September, they cooperated in a voter registration drive.

RELATIONSHIPS WITH COMMUNITY RESOURCES

Contractual agreements

The AC has a written contractual agreement with the Welfare Department in which the AC is informed of children under five known to the Department who need assistance, and Welfare is informed of families known to the AC that qualify for assistance.

The AC also has a written agreement with the John F. Kennedy Center for Child Developmental Research in Denver. One area of cooperation was previously described, relating to the diagnostic evaluation of children in 100 families in La Junta. Another area of cooperation is that the AC will identify high risk pregnancies, to whom JFK will offer diagnosis and treatment.

Referrals from other agencies

The Colorado Legal Rural Services makes periodic referrals to the AC. Recently five referrals were made to the AC in cases of suspected neglect, and need for emergency food and clothing.

The County Health Department has made three referrals to the AC to investigate the health of three different families.

The Welfare Department has been making about four referrals per month to the AC to investigate the needs of certain children.

Ongoing meetings with other agencies

The AC has been meeting with representatives of the Colorado Migrant Council semi-monthly since July. The CMC has been training the AC staff in such areas as improved interview techniques.

The Small Business Administration has met twice with the AC to assist in training of those responsible for consumer education, and for guidance in financial outlays.

The JFK Center has been meeting monthly with AC personnel since April to discuss and train staff in areas such as nutrition, social services, interview scales, and identification of high-risk children.

HUD personnel have met twice with AC staff to discuss crucial housing issues, e.g., discrimination, tenant rights, and self-help.

The Welfare Department has also met twice with AC personnel to discuss such issues as changes in the Food Stamp program, eligibility for welfare, and protective services.

The Manpower section of the Labor Department has met with AC staff once a month since April to discuss exployment, job discrimination, and employer's rights.

Representatives from the Advocacy Council, such as individuals from the Neighborhood Youth Corps have also met twice with AC staff to discuss all issues relating to children, e.g., recreation facilities, day care, comprehensive health planning, etc.

Agency coordination

The tri-county Advocacy Council was initiated by the Coordinator who sent letters to the heads of all local agencies servicing children, inviting them to aid in the formation of the Council. This has brought together a number of agencies which previously had not been meeting together. Coming together on the Advocacy Council allowed Welfare officials from the three different counties to see they had similar problems, and they now are learning from each other's experiences. Also, for the first time, the junior college personnel met with representatives from both Head Start and the Migrant Council which aided in gaining their cooperation in developing the model day care center. In addition, the council facilitated a meeting between PCC staff and public school representatives.

Changes in service delivery

As a result of AC efforts, a number of changes have been made. In general, the Coordinator feels that other agencies have become more sensitive to the needs of children, as a result of being in contact with AC.

While undertaking the needs assessment in Ordway, the AC staff became aware of a number of families needing homemaking services. The following case is illustrative:

An elderly man, his young wife and four children were living in deplorable housing. The house was in disrepair: the walls caked with dirt, the linoleum peeling, wiring exposed and animals, a goat, a pig, and some chickens, were living in the home. Dead chickens were found stuffed behind the stove.

The Welfare worker assigned to this case considered the mother and three of the four children to be mentally retarded. The caseworker believed the mother to be unable to raise the children and maintain a house and thus decided that the children should be removed from the home.

The Coordinator, upon becoming aware of this situation, proposed to the Director of Welfare that a homemaker be hired. The suggestion was rejected. The Coordinator then arranged with Welfare for the AC to hire a homemaker for a one-month trial period. If the home situation improved, it was agreed that Welfare would assume the costs thereafter.

The homemaker was able to produce a number of marked changes in the family. The mother began preparing adequate meals, developed a weekly schedule of responsibilities and activities, cleaned the house and took an interest in the children. The father also became more interested in the children and began to assume greater responsibility. The children were better cared for and cleaner; the home was more orderly.

These improvements in the family's situation were reported by the homemaker, in weekly reports, to the Director of Welfare. After one month he became convinced of the need for a homemaker, and Welfare is now assuming that cost.

Otero Junior College has established a model day care center for children aged three to five as a result of AC efforts. The Coordinator met with the dean of the college, and pointed out to him the need (based upon the AC needs assessment) for day care centers for children, and for a site to train day care staff in the tri-county area. They decided that the best area facilities for setting up such a center would be at Otero. After discussing the project with the college president, the dean wrote a proposal for the State Department of Education. The project was funded and the model day care center has been established. This model project for 30 children is now functioning with three staff members.

The president of Otero Junior College invited the Coordinator to teach a course entitled "Creative Activities Related to Children and Advocacy." Twenty students attend the twice-weekly class, at which a multi-media approach is used. The emphasis is on encouraging the students, who are all working with young children, or mothers, to understand and appreciate the perspective of children in a world of grown-ups, and to adjust accordingly to the needs of the children. The Coordinator is fully responsible for the course, but is consulting with one of the Otero professors on the general outline and specific problems. Reading assignments for the course are in child-oriented magazines, and creative arts and crafts books.

Attempts have been made to get the State Social Service Department to issue food stamps when they are needed, rather than on the day when the Welfare office gives them out. This objective has not yet been accomplished, but some progress has been made. The AC has written the State Social Service Department and the latter is to send a representative to the AC Office. This they have not yet done. The AC has also gone to the State Advocacy Coalition seeking assistance, and the latter body is also sending letters to the State Social Service Office, supporting the AC request.

The AC is also attempting to broaden the services of the Free Clinic, which is held once a month with volunteer doctors from Denver. Families are often more willing to go to this clinic than to the local clinics because they perceive it as less of a threat and because they may comfortably speak Spanish there. The AC would like to see the clinic held twice a month. Expansion of the Free Clinic is dependent on whether the two doctors and one intern who bring in all their own supplies from Denver will be able to come into La Junta more often.

RELATIONSHIP OF AC TO PCC

The La Junta AC and PCC have gone through a number of stages, some of which have involved conflict.

The Coordinator described the present relationship as "workable and harmonious." The PCC Director, and the AC Coordinator are creating "viable working relationships." There is a new PCC Board and the understanding is described as "the best since the inception of the AC."

Both the AC Coordinator and the PCC Director have suggested that the budgets be separated. There are a number of reasons for this. The AC staff feel they are asked to do too much work for the PCC, and thus cannot devote adequate time to AC activities. For example, one AC staff member was asked to write a manual for PCC parents. The housing specialist has been asked to work one half of his time on housing for PCC families. The resource specialist has been asked to devote a considerable amount of his time next month to working with PCC personnel.

The AC has been using the same accountant as the PCC and this has caused complications. When the AC Coordinator has requested certain financial information, there have been undue delays.

The PCC is reportedly seen by the community as a conservative body. Its primary function is seen as child stimulation. On the other hand, the AC has to stimulate more generalized community action, on behalf of its families. To accomplish things they have to become more aggressive and militant. If the AC and PCC remain financially tied, there is a concern on the part of the PCC staff that an aggressive approach by the AC could be detrimental to PCC activities.

Both staffs feel that there have been mutual advantages to working together. They have both learned from the child stimulation program, they make referrals to each other, they exchange and share information, they are able to attract better trainers and work through their techniques together, and they share certain facilities.

PROGRAM OBJECTIVES

The following are the seven objectives of this program:

- Information services regarding home budgeting public assistance; developing Consumer Guide to Resources.

- Assist in setting up multi-agency Child Advocacy Council.
- Effect model delivery system for children's services - referral, transportation, follow-through.
- Obtain mobile health unit visits, liaison with Colorado State Hospital, identify and aid high-risk pregnant women at JFK.
- Tenant Housing Committee to overcome housing problems.
- Assist in setting up and licensing of day care facilities (drop-in for mothers with problems).
- System of profile cards on children to record needs and progress.

Each of these will be discussed in turn.

- Information services regarding home budgeting, public assistance; developing Consumer Guide to Resources.

All of the agencies of the Advocacy Council have been asked to cooperate with this project, which was originally scheduled for completion by August 1st. Two other agencies have been independently working on different guides, but these other two guides contain no explanations in Spanish, do not list emergency services, do not list services devoted to aiding children, and they do not clearly explain how to reach certain resources. The Advocacy Guide is now scheduled for completion by December 1, 1972.

- Assist in setting up a multi-agency Child Advocacy Council

  This has been accomplished and the council has now been functioning for two months. The major council achievement to date, besides bringing together different agencies as described above, is preparing an information kit which documents the inadequacies of protective services for children. This has been sent to the State Advocacy Council in Denver, which will evaluate the information and perhaps legally challenge the state to provide more services.

- Effect model delivery system for children's services - referral, transportation, follow-through

  This has not been accomplished. The Coordinator feels that the major reason for this is that there are overlaps, conflicts, and contradictions among the services provided by different agencies. She states there is much duplication of effort, and that the services provided are primarily oriented to adults.

- Obtain mobile health unit visits, liaison with Colorado State Hospital, identify and aid high-risk pregnant women at JFK

  A mobile audiology unit visited Ordway for four hours one Saturday morning, but instead of the expected 20 children only four appeared. The Coordinator is not sure why this project had such a poor turnout, although she believes that the families are afraid of such a unit, due to their limited education and cultural superstitions.

Liaison with Colorado State Hospital has been effected through the regional representative to the State Advocacy Council. Plans are being made for AC aides to receive training from the hospital personnel in identification of children with mental health disorders.

A survey of pregnant women is currently being planned with JFK Center personnel. The goal is to identify high-risk pregnant women and to help them to overcome any difficulties which they may experience during pregnancy.

- Tenant Housing Committee to overcome housing problems

  The first meeting was on October 4th for the Morningside Housing Project and has been described above.

- Assist in setting up and licensing of day care facilities.

  The model day care center at Otero Junior College described above has been established and is successfully functioning.

  Plans are underway for a new day care center to be established in the Morningside Housing Project. A proposal has been written for HEW funding, but the Coordinator said that it needs to be rewritten.

Licensing of day care staff is a problem. There is a current paucity of individuals qualified to operate day care centers in the area. The Coordinator said that she feels the present state standards are too high in relation to local conditions. The problem in training many individuals, mothers in particular, is that they have neither the time nor the money necessary to attend classes to become properly certified. Certification at the junior college means 36 credits, i.e., 10 to 12 classes.

- System of profile cards on children to record needs and progress

  The cards have been made, but are not being used. The cards will contain such information as family needs, dates of referrals, contacts, appointments with physicians, etc. The cards will follow children through their various educational levels. The major problem in using the cards is a legal one, i.e., there is a concern that although these cards could be of major assistance to those aiding individuals as they mature, there is a concern that they might also fall into the hands of those who might not use the cards in the best interests of the children. Advice is now being sought from Colorado Rural Legal Services.

STAFF

Organization and background

There are 12 AC staff members. In addition to the AC Coordinator there is a Resource Specialist, a Health Coordinator who works directly with existing resources in the medical field and assists families in obtaining adequate medical attention, and a Housing Coordinator who works with existing housing resources in the community. He advises families and serves as a go-between for the families and housing agencies. There are seven advocate aides assigned to different geographic areas, almost all of whom have been recently hired, and their job is to meet with families. The twelfth staff member is the AC secretary.

Staff training

Staff currently participates in a number of different training efforts. First, JFK specialists are teaching a course on social service skills, nutrition, and test administration, two days per month at the junior college. These classes are academically oriented, with formal lectures, but there are no reading assignments, or homework. This is a non-credit course.

A professor of psychology and education at Southern Colorado State College, is teaching a series of courses every Friday for eight hours. These courses are oriented to the specifics of the AC job. He uses case histories without identifying families, and the best solutions to each problem are discussed in class. Creative problem solving is emphasized. The AC staff will receive credit for three courses upon completion of these courses.

Another course is planned which will deal with the cultural attributes of Americans of Mexican descent. Such items as folklore medicine, orientation to witchcraft, background in different traditions, and better understanding of the child in the Chicano family, will be taught.

The Coordinator plans to teach an informal course for interested AC staff on the mechanics of report writing. It will be held once a week for six weeks, a full day each time.

Also, the AC staff holds weekly meetings, which in a certain sense can on occasion be considered to be problem-solving sessions.

Three AC staff members are presently enrolled in the two year program at Otero Junior College. The Coordinator expects that they will receive their A.A. degrees by December 1973.

All of the AC staff have received at least a high school education. The AC Cordinator and the Health Coordinator have college degrees.

Staff turnover

Since the inception of the AC three staff members have left. The former Housing Coordinator left to continue his studies at a four year college. One of the advocate aides left because of pregnancy, and another was forced to leave because her husband did not want her to work.

CASE STUDY SEPTEMBER, 1972

ADVOCACY COMPONENT
OF THE
LEITCHFIELD PARENT-CHILD CENTER

Principal Author: Dorie Greenspan

LEITCHFIELD, KENTUCKY

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LEITCHFIELD

FAMILY CONTACT SUMMARY[1]

Number of different families telephoned for reason other than to schedule a home visit	27[2]
Total telephone calls to families, May through September	37
Number of different families visited in the home	71[2]
Total home visits to families, May through September	171
Number of needs assessments completed prior to May	280
Number of needs assessments completed since May	158
Total number of families dropping from "participation"	12

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[1] For period of May through September, 1972, inclusive.

[2] Total of monthly figures of different families contacted.

LEITCHFIELD

REPORT OF REFERRALS [1]	Numbers
MEDICAL REFERRALS	
ALL MEDICAL (sub total)	128
PERCENT OF TOTAL REFERRALS	(48)
Prenatal care	3
Neonatal care	3
Nutrition	
Immunization	6
Check-up	43
Medical coverage enrollment	
Hospitalization	1
Surgery	4
First aid	3
Medical appliance	1
Family planning	15
Eye examination	
Hearing problem	1
Speech problem	3
Dental examination	16
Dental problem	22
Medical miscellaneous	7
PSYCHOLOGICAL REFERRALS	
ALL PSYCHOLOGICAL (sub total)	
PERCENT OF TOTAL REFERRALS	
Psychological testing	
Retardation	
Psychiatric care	
Developmental/behavioral problem	
Psychological miscellaneous	
EDUCATIONAL REFERRALS	
ALL EDUCATIONAL (sub total)	12
PERCENT OF TOTAL REFERRALS	(4)
Adult basic education	
Private/special school enrollment	
Facilitating transportation	
College or equivalent enrollment	1
Head Start enrollment	5
Educational miscellaneous	6

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[1] Totals reported for May through September, inclusive.

LEITCHFIELD

EMPLOYMENT-RELATED REFERRALS

	Numbers
ALL EMPLOYMENT (sub total)	9
PERCENT OF TOTAL REFERRALS	(3)
Job rehabilitation	
Job training	
Job placement	8
Employment miscellaneous	1

HOUSING REFERRALS

ALL HOUSING (sub total)	14
PERCENT OF TOTAL REFERRALS	(5)
Home repair/improvements	
Furniture/appliances	3
Relocation (ruined quarters)	1
Relocation (more space)	9
Rent payment	
Eviction	
Housing loan	
Pest control	
Housing miscellaneous	1

WELFARE REFERRALS

ALL WELFARE (sub total)	11
PERCENT OF TOTAL REFERRALS	(4)
Food stamps	
Special welfare services	4
Increased welfare payment	
Welfare enrollment	1
Veterans Admin./Social Security	1
Welfare miscellaneous	5

MISCELLANEOUS REFERRALS

ALL MISCELLANEOUS (sub total)	93
PERCENT OF TOTAL REFERRALS	(35)
Help obtain clothing	28
PCC referral for enrollment	5
Legal problem	6
General transportation	10
Day care	5
Baby sitting	
Help obtain emergency food	23
General information/miscellaneous	16

TOTAL NUMBER OF RESOURCE CONTACTS	267 (100)

THE COMMUNITY

The Advocacy Component (AC) of the Leitchfield Parent-Child Center (PCC) shares its offices with those of the PCC and Head Start. It is in the basement of the old elementary school, the concrete construction is now pale green, and the hallways are filled with painted wild animals, colorful benches, and the sounds of children at lunch.

The catchment area

A visitor driving through the area for the first time is struck by the obviously poor condition of many of the homes. Homes on the road look like abandoned shacks or outbuildings from old farmhouses and the homes of the Advocacy families near the center of town are in no better condition. Many houses are made of wood with doors that no longer fit in their frames and boards that are miserably warped from rain, snow and lack of care. Indoor plumbing is not always available to homes on the back roads and in these houses space is generally inadequate for the size of the families.

Roads outside of the center of town are mostly unpaved and rough. Their condition is a match for the homes that line their sides. Streets in the town of Leitchfield are being torn up so that new gas lines can be installed.

The Leitchfield Advocacy Component serves both Grayson and Breckenridge Counties. Grayson County, which includes Leitchfield, a principal city, is a poor county with a population of approximately 18,000. The entire county budget is half that of the Advocacy Component, thus causing services in the community to be minimal.

The county is poor. There are only three factories in Leitchfield and were they to be taxed too heavily, they would move elsewhere, taking their three hundred employment positions with them. Small private shops and farms are the only other employers and taxable resources. The county cannot tax its residents as employment is low and jobs, if found, are seasonal. The average family income in Grayson County is approximately $1,500 per year.

Breckenridge County is fairly similar to its neighbor, Grayson. The Component's headquarters in Breckenridge is the new PCC satellite center in Axtel, approximately 20 miles from Leitchfield. This is a county of about the same size as Grayson, but no richer.

The target population

The families served by the Advocacy Component suffer from the many ills common to rural living and poverty.

They are an isolated population, isolated from each other as well as from the resources of the community. Although families may be unemployed and at home all day, socializing among families is not common.

The lack of transportation plays a large role in the degree of isolation. This is not a mobile population and the limited means of transportation increases the degree of isolation from community resources. A trip to the doctor must be arranged long in advance as a family cannot just drive there when necessary.

Although this is a fairly literate population, this is not an educated population. That is, they are not fully aware of what is available to them and what is necessary to prevent some of their many problems. For many families, their way of life is not only the only one they know, but it is the only one they can even dare hope to know. Expectations for the future are low because there is no precedent on which to base hope.

Employment, one means with which to change their situation, is minimal and seasonal. This is farm country and many of the Advocacy families are tenant farmers, that is, they live on the land on which they farm. This does provide them with housing, but salaries are extremely low.

A job paying $25 per week is nearly impossible to find and, if found, is considered a windfall. Despite the low income of the 280 families on whom needs assessments were completed, only 47 were receiving welfare and 60 were receiving commodities. The reason is that the amount of money available in Kentucky for welfare and commodities is determined by local county contributions and Grayson does not contribute much.

THE NEEDS ASSESSMENT

Prior to May, 280 family needs assessments were completed. Persons were found by a door-to-door survey of the area, and forms were completed by the Outreach Workers. In the period covered in this report, May-September, 158 additional needs assessments have been completed.

The Leitchfield needs assessment was done in three visits. The first visit served to introduce the Advocacy Component to the family and establish rapport between worker and client. The actual needs assessment form was filled out during the second visit. The third visit served to reinforce the groundwork laid during the initial home contact. Workers talked with the families and reminded them of the aims of the Component.

The process of completing needs assessment forms has been ongoing since the inception of the program, but there has recently been a change in the work. As a result of workers having difficulty with the form, and the National Office feeling that certain additional information should be collected, a new needs assessment form has been developed. It will be used in the field in October. This assessment will be completed by families different from those already interviewed.

While awaiting approval of the new form, Outreach Workers were in the field trying to locate pregnant women. Workers were completing "short forms," or information cards on these pregnant women and were planning to return to do "long forms," needs assessments, once the new forms came through.

Use of data

Information gathered from the needs assessment pointed out the necessity of adding two more objectives to the program. Both housing and transportation have become concerns of the Component. The Advocacy Coordinator said that prior to the needs assessment, he was aware of the community's problems, he just was not fully aware of the extent of these problems.

RELATIONSHIP WITH FAMILIES

According to data received monthly from the Component, there are 92 different families who have been either referred, visited in their homes, or referred and visited by the Advocacy Component. Forty-eight families were both visited and referred, 21 were referred only, and 23 were visited only.

Thus, it can be seen that staff made home visits to a total of seventy-one families. Monthly monitoring data show that fifty-one of these families were visited three times or less in the five month period (23 of these 51 families were visited once, 17 were visited twice, and 11 were visited three times). These data show that 28% of the 71 different families who are reported to have received home visits, were visited either four or five times in the five month period.

Referrals and follow-up

Referrals have been made for 69 different families. Monitoring data show that the range of referrals is from 1-13. Thirty-eight families have had one referral, 21 families have had between two and four referrals, 6 have had between five and seven referrals, and 4 have had between eight and thirteen referrals. The 69 families have been referred a total of 157 times. In order to effect these 157 referrals, 267 contacts were made with various resources. It is important to understand that in order to effect a single referral it is often necessary to contact more than one resource. The complexity of the process underlying referral can be illustrated through the use of a case example. A mother was referred for surgery to the infirmary in Louisville. In order for the surgery to be performed, the following resources had to be contacted: the local Health Department, the local doctor, Public Assistance, and the infirmary itself. Several of these resources had to be contacted more than once.

The Advocacy Coordinator estimated that approximately 75% of the families miss their initial appointment, but by the third appointment there is some specific outcome as a result of the referral being complete. This is, needless to say, frustrating to workers, and exasperating to agencies, especially doctors, who set aside appointment time.

High-risk and/or multi-problem families

It is the Coordinator's feeling that a multi-problem family is one with several problems that extend from one major problem; money usually being the major problem. As to high-risk families he stated that all the Advocacy families are high-risk.

When asked to cite an example of a "typical" problem family, the Coordinator told the case of an intact family with five children. "The mother seems rather intelligent, but she's behind, she's had a lot of children. The father is ill, he has been sent for physicals and the doctors say there is nothing wrong - it's all in his head. The doctors refuse to examine him further. The mother is a worker, she tries to make ends meet. She is concerned about her children. The house is in bad condition, but the mother tries to keep house. This is a low but pretty good family."

And indeed, this family is a pretty good family, its major problem is poverty. When the Outreach Workers returned from the field, they told the following story of one of their families:

This family lives with their several children in a shack, the front yard of which is a hog pen. The hogs move back and forth between the pen and the house. During a recent epidemic of hog colera, the workers were most concerned about the health of the children. The Outreach Workers visit this family very often as the woman has a new baby. There is always a problem seeing the baby, however, as the flies swarming around the crib are multitudinous. Workers bring fly paper and swatters to the family and try to emphasize the health hazard created by allowing the hogs in the house and the inevitable flies.

FAMILY GROUP PARTICIPATION

Mass meetings

The Leitchfield Advocacy Component has not held any mass meetings around particular issues nor have they given a project of this nature such thought. Transportation is such an overwhelming problem in this rural area that the Component does not see that it would be feasible for them to plan mass events with any degree of success.

Committees

The Advocacy Component has not formed any committees of AC families nor do they plan to in the near future. The Coordinator did speak of an abortive effort on the part of the PCC to organize such a committee.

There is one public housing project in Leitchfield that, according to the Coordinator, is not at all enjoyed by its residents. The PCC went into the project and tried to organize a tenants' grievance committee. The attempt was met with failure because, despite tenants' dissatisfaction, the families were afraid that their homes would be threatened if they organized. This fear of losing the little that is had is common not only to Leitchfield's Advocacy families, but to families served by many other programs.

Ongoing meetings

In May, 1972, the Leitchfield Advocacy Component began a series of pre-natal classes. Twenty women originally enrolled in the program, however, only eight women actually completed the 8-week course. Classes were coordinated with the Grayson County Health Department. The Health Department supplied several instructional films while Advocacy Component's nurse did the actual teaching.

The Coordinator views the course as a success and would like to start a new series in November, but the AC no longer has a nurse. At the present time, the Coordinator is attempting to hire a new nurse and is looking into the possibility of using the Parent-Child Center's nurse.

RELATIONSHIP WITH OTHER AGENCIES

Contractual agreements

To date, the Leitchfield Advocacy Component has not entered into any contractual agreements with any agencies. There are no plans, at this time, for any future contracts to be let.

Referrals from other agencies

The Component has received two or three referrals from the Public Assistance Office. The Coordinator says that when Public Assistance calls, the problem they are referring usually implies either transportation or a direct service that the AC is unable to supply. The Component has, however, been able to refer these families elsewhere.

The School Board has called the Component perhaps a dozen times. In these cases, the Board has most often found problems in the home and is uncertain as to how to handle them. The Board calls the AC to ask for information on appropriate referral resources and then deals with the problem and referral by themselves.

Ongoing meetings with other agencies

The Coordinator has done considerable and interesting work in this area. His efforts have led to the implementation of a County-wide Agency Conference, a forum for the discussion of problems, ideas, and goals. This Conference will be discussed at length under the subject of objectives.

Agency coordination

Although the Coordinator has modestly said that the Component's efforts have "not really" led to the coordination of services in the area, the County-wide Agency Conference has gone a long way toward making agencies more aware of one another. One important outcome of the Conference was an effort, on the part of all participating agencies, to decrease the amount of duplication of transportation being done by agency personnel. That is, agencies now call one another to see if it is possible to send one car, rather than two, to the hospital in Elizabethtown, or any such similar trip.

In an area where transportation is difficult, limited and time-consuming, this is an important innovation.

Changes in service delivery

The Grayson County Health Department has recently increased its available services in the area of family planning. It is not certain as to whether or not this was a result of Advocacy efforts.

The Coordinator had gone to the officials of the Health Department to speak to them about the possibility of their beginning a pre-natal and family planning clinic. The Department claimed that they could not legally have a pre-natal clinic, and that they did already dispense birth control pills.

Some time, shortly thereafter, the Health Department "beefed up" their family planning services and initiated an actual clinic. Mothers can now go to the clinic for both family planning counseling and instruction. The Coordinator has said that he does not feel that the Health Department would attribute the clinic's initiation to Advocacy efforts, but he does think that he was a catalyst.

Agencies in the community lack a substantial budget, and it is difficult to press for services if there is not enough money to institute these services.

RELATIONSHIP OF AC TO PCC

The Coordinator has characterized the relationship between the PCC and the AC as "close." The AC and PCC share joint in-service training sessions and, in two instances, share staff members. The Advocacy Nutritionist plans meals for the PCC and Head Start, and the PCC nurse does assist the Component. Both the AC and PCC make referrals to each other.

The Coordinator has said that what the relationship was supposed to be and what it actually is are two different things. The AC was to be a component, "but we're separated by budgets and the AC can't work with PCC parents."

PROGRAM OBJECTIVES

The following are the short-range objectives for the Leitchfield Advocacy Component:

- Assist in meeting medical and nutritional needs among pregnant women.
- Assist in meeting medical, nutritional, and dental problems in the remainder of the target population.
- Assist in child development and child care.
- Assist in the provision of legal and financial advice.

- Integration, mobilization, and creation of social service resources.

As a result of the still ongoing needs assessment two additional areas of concern were uncoverd:

- Transportation
- Improved housing conditions

Each objective will be discussed separately in terms of progress made toward achievement and process in implementing action.

Assist in meeting medical and nutritional needs among pregnant women

As will be seen, medical care in the catchment areas is a field beset with difficulties. However, one area of medical attention, pre-natal care, was found to be well covered by community resources and well used by community residents.

The Component had attempted to supplement the available pre-natal services by conducting its own series of pre-natal classes. As was discussed, the AC, in conjunction with the Health Department and the Component's nurse, did run an eight-week pre-natal course that was attended by, finally, eight women. Plans are in the making for another series.

With the exception of pre-natal care, in the area of meeting the actual medical needs of pregnant women, the Component has been plagued with problems. Grayson County has a 100-bed hospital with one doctor who delivers babies. The obstetrician, however, will only deliver 10 babies per month whereas the average number of births per month in the community is 20-22. This means that the 11th to the 22nd pregnant woman must go out of the County to have her child delivered. The Advocate has spoken with both the obstetrician and the Hospital Administrator about this problem, but has been unsuccessful in effecting any change.

One reason for this lack of success is the relationship between the community doctors and the hospital. Several of the town doctors are "feuding" with the hospital and so send their patients out of the County for service. In turn, the hospital has refused to allow some doctors into the institution and will not hire new doctors. There has recently been a glimmer of hope that this situation might change. The Hospital Administrator has left, and applicants for the position are now being interviewed. It is hoped that with a new administrator will come better service and increased cooperation between the hospital and the Advocacy Component.

The Coordinator had hoped to alleviate much of the delivery problem in Grayson County by hiring a mid-wife. To this end, he spoke with the Health Department about locating and using a mid-wife. The Health Department was only able to confirm the discouraging information the Coordinator had already obtained. It seems that Kentucky does have a school for Frontier Nursing that does train mid-wives. The problem, however, is that once a mid-wife is trained, she is used only in the vicinity of the school, thus making the chances of Leitchfield obtaining one poor.

The State, however, is considering adding a course in mid-wifery to its nursing curriculm. If this plan goes through, the Coordinator has already laid the groundwork in the Leitchfield Hospital, so it might be possible for Grayson County to get a mid-wife. In order for a mid-wife to work in the state, she must be sponsored by a doctor. The Coordinator has spoken with the obstetrician at the local hospital and he seems agreeable to the idea of sponsoring a mid-wife, if one can be located. The doctor has said that the reason he does not deliver more than ten babies a month is because he is kept very busy with the rest of his practice. He is willing to sponsor a mid-wife because he feels that she will be able to handle some of his work and leave him free to deal with special, more difficult problems. In addition, the mid-wife could be responsible for delivering babies during the night.

The Coordinator has made other efforts to improve medical service delivery in Leitchfield. He spoke with his Congressman regarding the possibility of the County getting a Public Health Clinic. The constraint in this area was the need for local matching funds in order to receive a grant for a clinic. The annual operating budget for Grayson County is $50,000, one half of the Advocacy budget. Of this $50,000, approximately $37,000 is earmarked for education, leaving very little money for administration of a County of 18,000 persons.

Medical care in Breckenridge County is better than that in Grayson, but is not without its problems. The Coordinator is a Grayson County resident and it is this County that he knows best. His knowledge of the resources in Breckenridge County is less extensive and he relies heavily on his Breckenridge Outreach Workers to negotiate the system. He was unable to say more about Breckenridge County's health services than that they were superior to those of Grayson County, especially in terms of hospital care.

To date, nothing in particular has been done in terms of meeting the nutritional needs of pregnant women. However, the Coordinator is now beginning to work with the Commodities Program in an effort to supply pregnant women with supplemental foods that are rich in protein, such as peanut butter and egg mixes.

service by purchasing and delivering the food and such action runs counter to the spirit of national guidelines for the program. The guidelines prohibit direct services unless families are receiving services from no other resource, as when other resources are simply unavailable. However, he does feel that an equitable solution to the problem will be arranged.

As a means to determining the dental needs of the population a dental screening was performed on a sample of community children. Advocacy workers took children to the dentist for the screening and if dental work was found necessary the AC paid for it as a "reward"for assisting in the needs assessment. (Again, the problem arose of the AC providing a direct service). Now that the screening is completed and a definite need has been found to exist, no further dental work has been done. The problem here is, again, lack of money. Medicaid will only pay for emergency dental work and families do not have the funds for needed dental treatment.

Assist in child development and child care

This is an objective that the Coordinator believes may either be dropped or at least given lower priority. The original thought behind this objective was to have Advocacy Workers go into the community looking for children with psychological problems or mental retardation, and prove a need for a special education class.

the experiment are being sought. While Outreach Workers are in the field attempting to locate pregnant women, they are also talking to expectant mothers about the possibility of their new child participating in the experiment.

Two problems have arisen with regard to this program, one practical and one budgetary.

Advocacy families in the Leitchfield catchment areas live miles apart, often in the back woods and most commonly on dirt roads that make access to the homes both difficult and uncomfortable. It is therefore frustrating to the Outreach Workers to travel to a family's home for a food delivery only to find the house locked tight and the family out elsewhere. The arrangement, as it now stands, for notifying mothers of the date of the food delivery is not very effective. It is expected that mothers will remember that workers come to their homes every two weeks with no reminder in the interim. It has recently been suggested that postcards be mailed to mothers a few days before delivery date in an effort to ensure that women will be at home and that workers will not have to make multiple trips.

The second problem involves the expenditure of Advocacy money for the purchasing of the baby food. As the Coordinator sees the problem, the Advocacy Component is providing a direct the long-range goal of convincing the Commodities Program of the desirability of including baby food in their packages.

The plan was to locate 30 experimental babies, from two months to six months of age, and 30 control babies. A supply of baby food would be delivered to the mothers of the experimental group every two weeks for six months. The babies would be weighed, measured, and checked by the nutritionist during the food delivery visit. Each child had a physical before joining the program and will have one at the end. In this manner the Component hopes to be able to show healthier development of the experimental babies.

At the present time there are 18 babies participating in the experiment, 12 in Grayson County and 6 in Breckenridge. Before enrolling babies in the experiment, parental permission was obtained and instruction in the proper feeding of infants was given to mothers. There are no control babies being monitored by the AC staff, but rather 30 case histories were compiled for comparison purposes. The babies on whom case history data are available are one year of age.

The Advocacy Component began buying and distributing the baby food on June 1st. Data collected so far seems to show that the experimental babies are steadily gaining weight and are sick less than the control group. Additional babies for

Assist in meeting medical, nutritional, and dental problems in the remainder of the target population

The Leitchfield Advocacy Component has not made a concentrated effort in the specific area of immunizations. The feeling here is that families know and use the Health Department so the Component can work in other fields. The original needs assessment shows an estimated 50 children having received no immunizations and an additional 125 (approximate) children partially immunized.

Childrens' medical problems are referred on an as-located basis.

Medical care for the target population is difficult to obtain. It appears that doctors in the community are not fully accepting their responsibility and are not making new doctors welcome in the town. Some doctors do not accept Medicaid and so patients are forced to go elsewhere. Going elsewhere, in turn, often involves the need for transportation and the payment of fees. The Advocacy Component has not been able to remedy the situation, however, they are facilitating transportation to other doctors for their families.

It is in the area of meeting nutritional needs of infants that the Leitchfield Component is doing its most innovative work. The Coordinator has instituted a baby food experiment with

However, shortly after the objective was formulated, a special education class was initiated by the School System.

Since resources do exist, the Advocacy Component no longer considers this to be a priority objective.

Assist in the provision of legal and financial advice

This objective has also been given lower priority and will be handled by the AC on an informal basis.

The Coordinator had hoped to advocate for the appointment of a Public Defender in Grayson County. Kentucky law states that every county must have a Public Defender. The process in Grayson County now is that each time a case comes before the court, the County Judge appoints a lawyer. The Grayson County budget, being as small as it is, does not allow for a salary to be paid to a permanent Public Defender.

When an Advocacy worker is asked by a family for an opinion as to the wisdom of a purchase, loan, or the like, the Coordinator is contacted. He in turn checks with the bank to verify a loan contract or to receive information on the integrity of a shopowner, etc.

Integration, mobilization, and creation of social service resources

The major accomplishment in this area has been the reinstatement of the County-wide Agency Conference in Grayson County. There had, at one time, been a County-wide Case Conference during which participating agencies would take turns in discussing specific cases encountered. The meetings were sponsored by the Department of Child Welfare, but were short-lived because of the amount of time needed by each agency for preparation.

When the Coordinator began to feel out agencies in terms of their cooperation in his Agency Conference, he made it clear that the agenda would be spontaneous and that preparation would be unnecessary. With this roadblock cleared, agencies were most willing to participate.

The Conference meets once every two months and has had two meetings to date. The first meeting served to introduce agencies to one another. During the second meeting, agencies discussed their overriding problems, with the result that lack of transportation was identified as the most common. The meeting also gave agencies the opportunity to introduce their new services and use the other members of the meeting as a sounding board. The Component's secretary attends all meetings, takes minutes, and sends each agency a copy.

The Coordinator feels that as a result of the Conference, better working relationships are being formed. He cites as an example the fact that prior to the Conference there was duplication of effort in some areas. It used to be that two agencies might send workers into Louisville, 60 miles away. Now, if a worker must make the trip, other agencies are called to see whether additional persons must go and if there can be a doubling up, or sharing, of transportation.

This idea was tested in Grayson County with agencies and persons that the Coordinator knew well. Now that it has proven successful, the Coordinator has scheduled a County-wide Conference in Breckenridge County. This should give Breckenridge agencies the chance to better acquaint themselves with each other.

Transportation

Public transportation is non-existent in Leitchfield and many families do not own cars. The roads, outside of the center of town are, for the most part, dirt. As a side light, the combination of poor roads and a small county budget causes children to lose as much as two months of school in the winter even if there are only three or four inches of snow. This lack of transportation means that appointments go unkept, that mass meetings of families are difficult if not near impossible, and that Outreach Workers must spend a good deal of the time transporting people to appointments. As Outreach Workers work most often in teams, the need to transport families often means a double loss of time. To solve the problem of transporting families without loss of worker time, the Advocate has asked Washington for permission to hire two transportation aides.

Housing

Large numbers of Advocacy families are renters or tenant farmers living in $20 to $30 per month "condemned" housing. Families are, according to the Coordinator unwilling to attempt to improve their homes simply because they do not own them and the landlords who do own them do not want to make repairs because the investment would be larger than the return. Most landlords do not look upon these rentals as a true source of income and would just as soon tear them down as improve them.

The Coordinator believes that home ownership is the key to the problem's solution, but this, as he points out, is not feasible. Most families owe multiple small debts and cannot afford even the low monthly costs necessary to get an FHA loan. The Coordinator is hoping to inquire at HUD and OEO, but has not yet done so although he is under the impression that their requirements will be similar to those for FHA.

There are approximately twenty "235 homes" in Leitchfield. These are homes built under a government contract and have low-interest, low monthly payment mortgages. However, these payments have proven to be too high. Some families have moved in, found it impossible to meet payment, and have moved out in a period of a few months.

While the solution may well lie in increased family income, employment in the Leitchfield area is very difficult to obtain. In Grayson County, with a population of 18,000 there are three (3) factories employing approximately 300 persons at minimum wage. Middle and upper level positions are filled by non-residents. Farming, the other source of livelihood for non and semi-skilled workers, is both seasonal and low paying.

The Coordinator would like the vocational school to arrange night classes so that the men in AC families could learn trades such as carpentry and automotive mechanics. The prospect here is dim on two counts: (1) the Coordinator mentioned trying to institute such classes 6 months ago and still there is no progress; and (2) even if classes were started and fathers enrolled, he admits that employment or even self-employment is hardly possible.

If the Coordinator were able to gain employment for all his AC families they would still find housing to be a problem as does the middle class in Leitchfield. There are no zoning regulations and no stringent building codes in Grayson County at present, nor does the government foresee instituting any in the future. This lack of restriction makes Grayson County a contractor's paradise. With no zoning regulations, homes can be built anywhere; without strongly enforced building codes, quality and safety control are left in the hands of the builders. The result, in one newly built community of homes, is raw sewage running through the streets.

Summary of objectives and progress toward achievement

There are marked difficulties in meeting the objectives, primarily as a function of the constraints of the situation. Resources are sorely limited with money being a major problem. What services do exist do so with a shortage of staff and funds, for the most part. Added to this is the frustration of working with families who are at times unable and at times resistant to following through on Advocacy initiatives.

STAFF

Organization and background

The Coördinator is a young man whose entire life, except for four years in college, has been spent in Leitchfield, Kentucky. His degree is a B.S. in zoology and his experience has included being a member of the City Council. It is his opinion that what qualifies him as an Advocate is not his past experience, but his long residence in Leitchfield and Grayson County.

Four Outreach Workers, all community residents, were hired; two were to work in Grayson County and two in Breckenridge County. One worker had had previous experience in the field as an Infant Educator in the Parent-Child Center Program; the others, though having no formal training in the field, shared a common enthusiasm to work on the program and see it succeed.

The structure of the Leitchfield AC is rather informal. Relationships among staff members are easy-going, and there is a shared understanding and sympathy for the day-to-day frustrations that must be faced.

The Coordinator acts as agency liaison and staff supervisor. Although he does not get much opportunity to visit families, he is familiar with many cases and is available to the Outreach Workers as a trouble-shooter, should they run into a problem they are unable to handle independently.

With the home office in Grayson County, the Coordinator does not, quite naturally, see his Breckenridge workers as often as he does those in Grayson. The Breckenridge team uses the PCC's new satellite center in Axtel as their base.

Each team of workers deals with families in their catchment area, making necessary referrals, often transporting families, and doing their own follow-up.

Staff turnover

Two nurses were hired for the Advocacy Component. They were hired, however, with the understanding that when the new Parent-Child Center budget was approved, they would then be shifted to the PCC Program and Advocacy would recruit a new nurse. A new nurse was hired, but she left shortly after the start of her employment because of her preference for hospital work.

During the summer a nutritionist was contracted by AC to work for one month on the newly begun baby food program. After one month it was agreed that the nutritionist would continue in her position permanently. "Permanent" was only to mean about three months, as the nutritionist has recently been offered the opportunity to take courses toward licensing and will be leaving at the end of September. It is the Coordinator's hope to hire a new nutritionist; however, the position is a difficult one to fill. There is no other agency in Grayson County employing a nutritionist, so even the possibility of sharing a staff member part-time is dim.

Training

The staff does receive periodic, but regular, in-service training to assist them in their work. Training sessions are conducted by members of Western Kentucky State College and can take the form of seminars, workshops, or lectures. The most recent session was a lecture on interviewing techniques followed by group participation in actual interviewing. In addition, last spring the entire PCC and AC staff enrolled in an extension course in speech and received three hours of college credit. Case evaluation is given by the Coordinator on an as-needed basis.

DATA FROM THE INFORMATION SYSTEM

REFERRAL AND CONTACT DATA

Appearing in the following tables are summary data on referrals for all seven Advocacy Components for the period May - September 1972, inclusive. Figures are broken out to show the client individual(s) involved, the reported outcome, and the AC's role(s) in the referral.

Presented below, in Table 1a, are the numbers of individuals in contact with the Advocacy Component, according to types of resources contacted.

Table 1a. Contacts to resources: type of referral, and category of individuals involved (May-September 1972).

			TYPE OF REFERRAL						
INDIVIDUALS INVOLVED		TOTAL CONTACTS TO RESOURCES	MEDICAL	PSYCHOLOGICAL	EDUCATIONAL	EMPLOYMENT RELATED	HOUSING	WELFARE	MISC.
Child	N	626	378	9	26	-	2	4	207
	%	(39)	(49)	(47)	(52)	-	(1)	(4)	(52)
Parent	N	350	174	4	12	46	7	28	79
	%	(22)	(22)	(21)	(24)	(82)	(3)	(30)	(20)
Expectant Mothers	N	93	64	-	2	1	4	2	20
	%	(6)	(8)	-	(4)	(2)	(2)	(2)	(5)
Other Family Members	N	39	16	3	6	6	2	2	4
	%	(2)	(2)	(16)	(12)	(11)	(1)	(2)	(1)
Whole Family	N	489	143	3	4	3	188	58	90
	%	(31)	(18)	(16)	(8)	(5)	(93)	(62)	(23)
Total Number of contacts to resources	N	1,597	775	19	50	56	203	94	400
	%		(48)	(1)	(3)	(4)	(13)	(6)	(25)

Bottom line percentages are row percentages.

Note: Each whole family = one contact to resource.

As will be noted from an inspection of Table 1a, 1,597 contacts to resources were made on behalf of Advocacy families. Medical referrals account for almost half of the total number of referrals; most of these, in turn, are on behalf of children. Second in order of frequency of referral activity is the category "miscellaneous." Included here are referrals for clothing, for enrollment at the Parent-Child Center, for enrollment at Day Care Centers, and for general information regarding other services. Approximately 13% of all referrals are for housing, most often on behalf of the whole family. Generally, fewer than one in twenty referrals were made for any of the other areas, i.e., psychological, educational, or employment.

Turning now to the question of outcome, data relating to the nine possible levels of outcome are presented below, in table 1b.

Table headings for referral outcome appear as numbers. The larger the number, in general, the greater the degree of positive action that has resulted. Thus, code 9 is the "best" outcome. The numerical codes are as follows:

1 = No report of outcome.

2 = Appointment made but not kept; end of referral.

3 = Appointment made but not kept; new appointment made or to be made.

4 = Problem unresolvable (family ineligible, insufficient resource, etc.).

5 = Appointment kept, no action by resource.

6 = Promises made by resource, but no action yet.

7 = Partial solution; end of case.

8 = Partial solution; more expected.

9 = Problem resolved.

Table 1b. Contacts to resource: type of referral and level of outcome (May-September 1972).

LEVEL OF OUTCOME		TOTAL CONTACTS TO RESOURCES	TYPE OF REFERRAL						
			MEDICAL	PSYCHOLOGICAL	EDUCATIONAL	EMPLOYMENT RELATED	HOUSING	WELFARE	MISC.
1	N	64	20	3	3	1	19	4	14
	%	(4)	(2)	(16)	(6)	(2)	(9)	(4)	(4)
2	N	14	8	-	-	1	2	1	2
	%	(1)	(1)	-	-	(2)	(1)	(1)	(1)
3	N	27	11	1	-	2	2	-	11
	%	(2)	(1)	(5)	-	(4)	(1)	-	(3)
4	N	38	5	-	-	1	14	10	8
	%	(2)	(1)	-	-	(2)	(7)	(11)	(2)
5	N	35	2	-	1	2	17	6	7
	%	(2)	(*)	-	(2)	(4)	(8)	(6)	(2)
6	N	265	48	8	16	26	68	23	76
	%	(16)	(6)	(42)	(32)	(46)	(33)	(24)	(19)
7	N	5	-	-	1	4	-	-	5
	%	(*)	-	-	(2)	(7)	-	-	(1)
8	N	382	201	4	2	8	46	13	108
	%	(24)	(26)	(21)	(4)	(14)	(23)	(14)	(27)
9	N	767	480	3	27	15	31	37	174
	%	(48)	(62)	(16)	(54)	(27)	(15)	(39)	(44)
Total Outcome	N	1,597	775	19	50	56	203	94	400
	%		(48)	(1)	(3)	(4)	(13)	(6)	(25)

Bottom line percentages are row percentages.

* Less than 0.5 percent.

Seventy-two percent of the 1,597 contacts to resources had either a successful outcome (48%) or a partial resolution with full resolution anticipated (24%).

Sixty-two percent of all medical referrals resulted in the problem being resolved, and 26% resulted in the problem being well on its way toward solution. In only twenty cases, i.e., in only 2% of all referrals, was there no reported action; in less than 1% of cases was an appointment not kept and no further action taken. A somewhat lower level of successful outcome is reported with respect to other services. Referrals for employment, psychological services, education, housing, and welfare tend to take longer before resolution occurs. In other words, no matter how willing the resource, finding a job or new housing or acceptance at an educational facility may involve considerable delay.

Table 1c. Contacts to resource: type of referral and AC involvement (May-September 1972).

AC INVOLVEMENT *		TOTAL CONTACTS TO RESOURCES	TYPE OF REFERRAL						
			MEDICAL	PSYCHOLOGICAL	EDUCATIONAL	EMPLOYMENT RELATED	HOUSING	WELFARE	MISC.
No Report	N	93	50	1	7	7	5	2	21
	%	(2)	(2)	(2)	(6)	(5)	(1)	(1)	(2)
Made appointment	N	931	533	11	17	17	109	40	204
	%	(22)	(23)	(24)	(15)	(12)	(23)	(18)	(21)
Facilitate transportation	N	422	335	4	3	6	14	15	45
	%	(10)	(15)	(9)	(2)	(4)	(3)	(7)	(5)
Accompany individual	N	282	199	4	4	5	21	19	31
	%	(7)	(9)	(9)	(3)	(3)	(4)	(8)	(3)
Supply information	N	707	267	7	31	40	123	57	182
	%	(17)	(12)	(16)	(27)	(28)	(26)	(25)	(19)
Follow-up resource	N	866	444	7	22	29	110	45	219
	%	(20)	(20)	(16)	(19)	(20)	(23)	(20)	(23)
Follow-up individual	N	923	445	11	32	41	93	49	252
	%	(22)	(20)	(24)	(28)	(28)	(20)	(22)	(26)
Total Involvement	N	4,224	2,273	45	116	145	475	227	955
	%		(54)	(1)	(3)	(3)	(11)	(5)	(23)

* Multiple answers occurred.

Note: Bottom line percentages are row percentages.

In making the 1,597 contacts to resources, 4,224 actions are reported by the AC's. In making medical and psychological referrals, the primary activities are making the appointment and follow up both to the individual and the resource. In terms of meeting the educational and employment needs of AC families, follow up to the individual and supplying information are the most common activities. In the housing and welfare, accivities are rather evenly divided between supplying information, making appointments, and follow up. In all other areas, activity centers primarily on making appointment and follow up. It is important to note that facilitating transportation accounts for one out of ten AC actions with regard to referrals, and accompanying AC families to their appointments accounts for 7% of all AC actions.

The following tables deal with more detailed subdivisions within each of the major categories presented above. Turning first to medical referrals, presented in Table 2 are data on specific types of medical referrals.

Table 2. Contacts to medical resources.

TYPE OF REFERRAL	NUMBER	PERCENTAGE
Pre-natal care	46	6
Post-natal care	8	1
Nutrition	64	8
Immunization	99	13
Check-up	162	21
Medical coverage enrollment	207	27
Hospitalization	8	1
Surgery	7	1
First aid	7	1
Medical appliance	3	*
Family planning	44	6
Eye examination	5	1
Hearing problem	3	*
Speech problem	5	1
Dental examination	21	3
Dental problem	50	6
Medical misc.	36	5
All medical	775	101

* Less than 0.5 percent

Almost two-thirds of all medical referrals involve immunization, check-up, and/or medical coverage enrollment. It should be noted that the number of immunizations represents a lower bound estimate, because frequently immunization occurs as part of a well-baby check-up or as part of enrollment in a medical facility or plan. Such immunizations are not reported as such, rather, the enrollment for coverage or check-ups are reported.

Turning now to psycnological referrals, data reflective of the number of such referrals made are presented below, in Table 3.

Table 3. Contacts to psychological resources.

PSYCHOLOGICAL REFERRALS	NUMBER	PERCENTAGE
Psychological testing	1	5
Retardation	7	37
Psychiatric care	6	32
Developmental/behavioral problem	5	26
All psychological	19	100

Relatively few referrals for psychological services have been made. Thus, it is not particularly meaningful to speak of percentages occurring within each sub-category.

Similarly, as will be seen below in Table 4, educational referrals comprise only a small percentage of all Advocacy Component work.

Table 4. Contacts to educational resources.

EDUCATIONAL REFERRALS	NUMBER	PERCENTAGE
Adult basic education	9	18
Private/special school enrollment	12	24
Facilitating transportation	1	2
College or equivalent degree	1	2
Head Start enrollment	16	32
Educational misc.	11	22
All educational	50	100

Table 5. Contacts to employment-related resources.

EMPLOYMENT-RELATED REFERRALS	NUMBER	PERCENTAGE
Job rehabilitation	1	2
Job training	22	39
Job placement	31	55
Employment misc.	2	4
All employment	56	100

Almost all employment-related referrals were for job training or job placement. In referring back to the data presented in Table 1b, it will be noted that the majority of these referrals resulted in some form of definitive action being taken;

this may suggest, in turn that, given the usual paucity of job openings, AC's make such referrals only when there is some probability of successful outcome. This "reality factor" may account in part for the seemingly low emphasis placed upon employment referrals in the Advocacy Component.

Table 6. Contacts to housing resources.

HOUSING REFERRALS	NUMBER	PERCENTAGE
Home repair/improvements	26	13
Furniture/appliances	18	9
Relocation (ruined quarters)	64	32
Relocation (more space)	45	22
Rent payment	7	3
Eviction	8	4
Housing loan	2	1
Pest control	18	9
Housing misc.	15	7
All housing	203	100

Over half of all housing referrals were made for relocation; as a function of families residing in impossible quarters, or in quarters which do not provide enough space.

As was noted in the discussion relating to Table 1b, it is with regard to housing referrals that the Advocacy Components appear least successful in stimulating action. That is, in only 15% of the referrals have the problems been totally resolved; in contrast to most other referral categories, many of the Advocacy clients are placed on agency waiting lists.

Table 7. Contacts to welfare resources.

WELFARE REFERRALS	NUMBER	PERCENTAGE
Food stamps	25	26
Special welfare services	17	18
Increased welfare payment	18	19
Welfare enrollment	12	13
Veterans administration/ social security	3	3
Welfare miscellaneous	19	20
Total welfare	94	99

Six percent of all referrals are made to meet welfare needs. As shown in Table 7, above, over half of all of the welfare referrals are made for specific types of service: food stamps (26%), special welfare services (18%), increased welfare payment (19%), and welfare enrollment (13%). While some of these referrals result in individuals being placed on agency waiting lists, by far the greatest number of referrals result either in successful resolution, or in partial resolution, with full resolution imminent.

Finally, referral to miscellaneous resources included the categories presented below, in Table 8.

Table 8. Contacts to miscellaneous resources.

MISCELLANEOUS REFERRALS	NUMBER	PERCENTAGE
Help obtain clothing	44	11
PCC referrals for enrollment	131	33
Legal problems	20	5
General transportation	25	6
Day care	60	15
Babysitting	11	3
Help obtain emergency food	35	9
General info/misc.	74	18
Total miscellaneous	400	100

The single numerically largest category of referral was for PCC enrollment. By and large the other categories reflect specific, often acute service needs: provision of clothing, emergency food, transportation, day care, etc. As will be noted from Table 1b, the great majority of these referrals resulted in either total resolution, or partial resolution with total resolution imminent.

APPENDIX A:

INTERVIEW GUIDE

Advocacy Questionnaire
Director - September, 1972

1. Locating Families and Needs Assessment

1a. The objectives that were written into your proposal and then finalized in Wisconsin were done, for the most part, before you completed your needs assessments. Now that the needs assessment are finished, have your objectives changed? (Note: Probe for objectives which have been dropped and/or added. This is the time to discuss each of the local objectives on the Wisconsin List - specific to this AC and to find out for each whether it is being pursued or has been dropped).

( ) NO
( ) YES, How? ______________________________

1b. (Use as Probe)
Did the needs assessment teach you anything about the community you didn't already know?

( ) NO
( ) YES, What? ______________________________

2. Some people have said that the chief value of the needs assessment has been not so much a question of getting to know the needs of the community, but in gaining entre to homes. In other words, would you say the needs assessment was more useful as:

a. ( ) a technique for gathering new information

b. ( ) a technique of case finding

3. If (b), do you feel there could be another way of finding AC families? Could you have gone door-to-door and had an informal chat rather than formal questionnaire?

4. If (a), and you feel you really got useful information could you describe exactly how you have used the information from the needs assessment to structure and organize your program?

5. Would you recommend a needs assessment to a new AC starting up?

6. Has any other agency used the information from, or your actual needs assessments?

( ) No
( ) Yes - Which Agency(ies) ____________

For What Purpose? ____________

Relationships with AC Families

7. How many target families does your AC work with? (To mean families with which AC has ongoing contact.)

______

____

____

8. What is the mechanism(s) by which you maintain contact with individual families for whom you are not making specific referrals?

-- Families call AC — Estim. % ______

-- Outreach worker makes regular periodic home visits — Freq. ______

-- Workers makes regular phone calls — Freq. ______

-- Meetings at AC — No. Attending ______

9. What is the proportion of families, out of all those you have, for whom you've made at least one referral which has already resulted in a specific outcome, e.g., an immunization, a dental visit, a housing change?

Percent ______

10. When CCR was making its first AC visits back in April, 24% of the families as we said in our report didn't know who or what AC is. How do you think it is now, do all your 100+ families know what you're all about at this point?
(PROBE: How have you gone about making the AC more visible?)

____

____

____

____

11. Some advocates have expressed the feeling that it's harder to make an impact on families than they had expected, many appointments aren't kept, people don't turn out for meetings, committees have been hard to form, etc. Let's talk about the frustrations of being an advocate for a moment. To what extent are these frustrations a function of the families you serve? (Do not read choices - this is not a Likert item.)

( ) Great extent
( ) Some extent
( ) No extent

____

____

____

____

____

12. Could you estimate what % of referrals are made by AC but not carried out by families?

_______________%

(If can't give a % ask the following:)

( ) About 1/2
( ) About 1/4
( ) In between 1/4 and 1/2
( ) Less than 1/4

If % is high, ASK: Have you attempted to lessen this percentage? How? (Look for process of follow-up?)

____

____

____

____

____

13. To focus specific attention on the children of high-risk or multi-problem families was one of the national objectives for the Advocacy Components. After working with families, many of whom probably fall into this category, do you have a clearer or different idea of just what constitutes a high-risk family?

Perhaps you could give me an outline of such a family?

14. Have you had any mass meetings around particular issues, i.e., health, benefits, housing?

( ) Yes - What meetings? (List by issue)

ISSUE	% MEMBERSHIP

If turn-out is poor - why?

( ) No

If No:

Have you tried to do this at some point, but it just didn't work? Have you thought about doing this type of thing?

15. Have you formedany committees of AC families?

( ) Yes

Specific Committee by Title	Freq. of / Total # of Meetings	% Coming

Are these committees still on-going?

( ) No

Have you tried at some point, but it just didn't work?

16. Have your formed any regular ongoing groups, e.g. teenage rap sessions, pre-natal.

( ) Yes

Sepcific Group	Freq. of	Total # of	% Coming
	Meetings		

Are these groups still ongoing?
Has a new cycle of groups begun?

17. Before we move off of the families and on to the agencies, I'd like to ask you if there's anything else about serving families I haven't asked that you want to say?
(Probes - if the above material doesn't cover it.)

a. Have you learned anything you didn't know when you started out?

b. Any new techniques for getting families?

____

____

____

c. For maintaining involvement?

____

____

____

d. For making sure referral appointments are actually kept?

____

____

____

Community Resources

It's quite clear that every AC has acquired some specific and detailed knowledge about services available. When CCR was here in April and we interviewed at agencies, most agencies had had a meeting or two with you which were essentially orientation and get acquainted meetings. We know that some ACs have gone beyond that with some agencies and that's what I'm going to ask about now.

18. Are there any agencies with which you have a formal contractual agreement (e.g., agency provides a nurse, hospital pre-natal care)?

Are there any agencies with which you have tried to make agreements, but did not succeed?

( ) No -
( ) Yes - List Name

Exact nature of agreement
(who does what)

a. ____________________ ____________________

____

____

____

____

b. ____________________ ____________________

____

____

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c. ____________________ ____________________

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d. ________________________ ____________________________

e. ________________________ ____________________________

f. ________________________ ____________________________

g. ________________________ ____________________________

h. ________________________ ____________________________

i. ____________________ ____________________

j. ____________________ ____________________

(For each of above, on a separate page, get full process of how this agreement came about and what went into making it happen).

19. We know that you make referrals to a number of different agencies. Are there any agencies that make referrals to you?

( ) No ( ) Yes - List Name	Approx. # of Referrals	Referrals for what
a. ____________________		
b. ____________________		

c. ____________________ ____________ ____________

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d. ____________________ ____________ ____________

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g. ____________________

h. ____________________

i. ____________________

j. ____________________

20. Are there any agencies with which you have ongoing meetings (at least monthly, does not include an AC worker talking to another worker. This refers to policy-making meetings)

Are there agencies with which you have tried but did not succeed?

( ) No ( ) Yes - List Name	Freq. of	Total of	Purpose of Meetings
a. ____________________	______	______	____________
	______	______	____________

	______	______	______
	______	______	______
b. ______________	______	______	______
	______	______	______
	______	______	______
	______	______	______
	______	______	______
c. ______________	______	______	______
	______	______	______
	______	______	______
	______	______	______
	______	______	______
d. ______________	______	______	______
	______	______	______
	______	______	______
	______	______	______
	______	______	______
e. ______________	______	______	______
	______	______	______
	______	______	______
	______	______	______
	______	______	______

f. ______________________ __________ __________ ______________

g. ______________________ __________ __________ ______________

h. ______________________ __________ __________ ______________

i. ______________________ __________ __________ ______________

j. ______________________ __________ __________ ______________

21. There may be a few agencies which are actually doing something different in the services they deliver because of AC efforts (e.g., heightened freq. of nurse at immunization clinic. homemaker service by Dept. of Welfare, reduced hospital waiting time, new facility on drawing boards). Are there any precedent-breaking things like that which have happened?

( ) No
( ) Yes - List Name of Agency Specific change

a. ______________________ ______________________

b. ______________________ ______________________

c. ______________________ ______________________

(For each agency listed above, get full story on back sheets as to the process of how this change came about.)

22. Are there any agencies which have gotten connected to each other as a result of AC efforts?

( ) No
( ) Yes - List Title   Outcome

a. ____________________   ____________________

b. ____________________   ____________________

c. ____________________   ____________________

(Again, get process of how this happened).

23. Way back in Wisconsin you spoke of changing the agencies, increasing their sensitivity. Has this been a major thrust of this AC?

( ) No - Why? ____________________
( ) Yes

24. Have you learned anything about how hard or easy it is to make changes in service integration and delivery that you didn't know before?

( ) No
( ) Yes - What? ____________________

25. How would you describe the ACs relationship to the PCC?

- neutral
- hostile - Why? ____________________
- close

If close:
Do the following occur:
- joint staff meetings
- shared staff
  both staffs work for both PCC and AC
- PCC staff works with AC families
- AC staff works with PCC families

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26. Have you compiled a Resource Guide?
May I have a copy to take back?

27. Before we move off of the community agencies and services is there anything I haven't asked that you want to tell me?

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Staff Training

28. Is your staff getting any training now?

( ) No
( ) Yes - a. How often? ____________________

b. How long? ____________________

c. By whom? ____________________

d. Group vs. individual ____________________

e. Trainer (Advocate, PCC, outside) ____________________

29. (Get a detailed description of how this is done - process - is it supervision on cases seen, theory, academic, etc.)

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30. Are any of your staff enrolled in any course work?

( ) No
( ) Yes - Degree expected ____________

How much time ____________

31. Have you lost any staff since AC began?

( ) No
( ) Yes - How many? ____________

What positions? a. ____________

b. ____________

c. ____________

d. ____________

e. ____________

Reasons for termination of each person mentioned in a-e above.

32. Is there anything else about staff you want to say (e.g., major weaknesses or strengths of staff, etc.)?

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